MEDICAL STAFF
RULES AND REGULATIONS

April 23, 2025

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DEFINITIONS

The defined terms in the Medical Staff Bylaws are adopted by reference into these Rules & Regulations.

1. "Advanced Practice Professional" or "APP" means an individual, other than a Practitioner, who is qualified within the limitations of their license and credentials as required by state law to exercise independent professional judgement or to be accorded privileges to render medical or surgical care under the supervision of or in collaboration with a licensed practitioner Medical Staff appointee who has been accorded the comparable privileges to provide such care in the hospital. Such APPs may include, but are not limited to, physician assistants and advanced practice registered nurses (i.e. Certified Nurse Practitioner, Certified Nurse Midwife, Clinical Nurse Specialist, Certified Registered Nurse Anesthetists) who are granted privileges ("mid-level providers") or other Practitioner directed APPs who practice pursuant to a scope of service/position description recognized by the hospital, but who may not in any event include chiropractors. For purposes of the bylaws, "Advanced Practice Professionals" shall not be deemed to include those non credentialed individuals ("Clinical Assistants" pursuant to the hospital policy) whose appointment and competencies are handled outside the Medical Staff process.

2. "Board of Trustees" or "Board" means the Board of Trustees of Clinton Memorial Hospital.

3. "Clinical Privileges" or "Privileges" means the Board's recognition of an individual's competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services

4. "Day" means a calendar day unless otherwise specified in a particular context as "working day." A working day does not include weekends or federal holidays.

5. "Dentist" means an individual with a D.D.S. degree, or its equivalent, who is fully licensed to practice dentistry and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

6. "Hospital" means Clinton Memorial Hospital.

7. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

8. "Medical Staff" or "Staff" or "Organized Medical Staff" means the formal organization of Practitioners who have been granted Medical Staff membership.

9. "Medical Staff Appointee" or "Appointee" shall mean a Practitioner who is fully qualified for and has been granted appointment to the Medical Staff.

10. "Medical Staff Rules and Regulations" means the Medical Staff document containing the Rules and Regulations of the organized Medical Staff as set forth in this Medical Staff document.

11. "Physician" means a graduate of an approved medical or osteopathic school of medicine who is licensed in the State of Ohio or any other state to practice medicine.

12. "Podiatrist" means an individual with a D.P.M. degree who has an unrestricted licensed to practice podiatry.

13. "Practitioner" means a Physician, Dentist, or Podiatrist who has been granted clinical privileges and/or Medical Staff membership in the Hospital.

14. "Prerogative" means a participatory right granted, by of the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

15. "Chief Executive Officer" or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

16. "Psychologist" means an individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who has an unrestricted license to practice psychology.

17. "Telemedicine" aka "Telehealth" means the use of electronic equipment or other communication technologies to provide or support clinical care at a distance.

Every reference to an officer (e.g., "CEO," "Chief of Staff," "Director of Medicine," "Director of Surgery," etc.) in the Rules and Regulations, shall mean the officer "or the officer's designee" and shall allow a designee to be substituted for the officer, unless otherwise provided.

ARTICLE I: ADMISSION AND DISCHARGE

SECTION 1.1 ADMISSION OF PATIENTS

A. Except in emergency, all patients require a diagnosis upon admission. When a provisional diagnosis is not known it shall be so stated. If the Practitioner's documentation does not reflect the intensity of service or severity of illness in accord with the Utilization Management Plan approved by the Utilization Review Committee, a request may be made to the Attending Practitioner to provide additional information.

B. Admitting Practitioners shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of patient from self-harm. (Refer to Hospital Infection Prevention & Control Plan.)

C. A complete history and physical examination shall in all cases be documented in the electronic medical record or dictated and included in the electronic medical record within 24 hours after admission to the inpatient service. (Refer to Article III: Section 3.2-1.)

D. Admission of a patient to the Hospital inpatient service shall be specifically ordered by a Practitioner with admitting Privileges and shall be medically indicated. Patients meeting inpatient criteria approved by the Utilization Review Committee shall only be admitted as inpatients. Patients assigned to Observation Status remain outpatients and may be assigned to Observation Status solely in accordance with the criteria and rules set forth below in Article I: Section 1.5: Observation Status.

E. All patient transfers into the Hospital, as well as direct admissions, will be accomplished according to Hospital policy.

SECTION 1.2 ADMITTING PRIVILEGES

As per Medical Staff Bylaws Section 6.3, only Staff Appointees may be granted admitting Privileges.

SECTION 1.3 PRACTITIONER/APP NOTIFICATION OF PATIENTS ADMITTED TO HOSPITAL

Whenever feasible the primary care Practitioner/APP will be notified when a patient is admitted unless the patient desires otherwise.

SECTION 1.4 DISCHARGE OF PATIENT

Patients shall be discharged only on order of the Attending Practitioner at the time of discharge. All patient transfers out of the Hospital will be accomplished according to Hospital policy.

SECTION 1.5 OBSERVATION STATUS

A. Definition

Observation Status (a timeframe of 24-48 hours) is the unscheduled use of a Hospital bed to evaluate an outpatient's condition to determine the need for inpatient admission or discharge.

B. Criteria for Observation Status

Assignment of a patient to Observation Status requires the Practitioner's documentation that the patient meets one of the following criteria:

1. The patient's diagnostic evaluation requires more prolonged services than what is typically accomplished in the Emergency Department or outpatient setting; or
2. The patient requires monitoring or treatment beyond the usual recovery time due to an unexpected occurrence or complication following an outpatient procedure (for example: abnormal bleeding, uncontrolled pain, vomiting, and/or delayed recovery from anesthesia).

Also, Observation Status is not acceptable for:

1. Routine prep or recovery prior to or following diagnostic or surgical services;
2. Custodial care and/or as a convenience to patient, family, hospital, or Practitioner/APP;
3. Physical medicine and rehab care;
4. Patients receiving therapeutic services (chemotherapy, dialysis, blood transfusions not associated with acute blood loss) routinely provided in the outpatient setting;
5. Determining the labor status of a maternity patient; or
6. Patients requiring critical care treatment and monitoring; or
7. Patients waiting for nursing home placement.

C. Other Requirements

1. Patients shall not be scheduled for Observation Status. A patient may only be scheduled as an outpatient or an inpatient. The Attending Practitioner may decide after an outpatient procedure that a patient meets criteria for Observation Status.
2. A complete history and physical examination shall in all cases be documented in the electronic medical record or dictated and included in the electronic medical record within 24 hours after assignment of the patient to observation status. (Refer to Article III: Section 3.2-1.)
3. Documentation must provide a description of the medically unstable condition for which the patient is being observed, the patient's signs and symptoms, the treatment provided and the response to treatment.

SECTION 1.6 ASSESSMENT OF THE PATIENT

A. There shall be a patient assessment completed by the Practitioner performing the procedure for invasive procedures, epidurals, percutaneous biopsies, and stress tests. The scope of the assessment will be medically appropriate to the procedure as determined by the Practitioner performing the procedure.

B. For Anesthesia see Article II: Section 2.1.

C. For surgical procedures patient assessments see Article II: Section 2.5-1.

SECTION 1.7 CONSULTATIONS

A. The attending Practitioner is encouraged to consider consultation with another Practitioner in the following situations.

1. If the patient is considered to be a high surgical, medical or psychiatric risk.

2. If the patient's diagnosis is obscure after appropriate workup.

3. Care of the patient requires assistance from another discipline.

B. Except in an emergency, consultation with an OB-GYN Physician holding core Privileges shall be required, but not limited to the following conditions: High risk pregnancy when primary C-Section might be indicated; curettage or other procedure by which a suspected viable pregnancy might be interrupted; history of erythroblastosis fetalis; severe pre-eclampsia or eclampsia; antepartum, postpartum or puerperal hemorrhage or sepsis; dystocia; any abnormal position, presentation or development of fetus; abnormal third stage of labor; multiple pregnancy; diseases of cord; membranes, or placenta; fetal distress; disorders of puerperium.

C. Any patient on mechanical life support longer than 24 hours shall have a consult with a Hospitalist, Internist or Pulmonologist. This provision shall not be read to preclude such consultation prior to the end of the 24-hour period where medically appropriate.

D. In Article I: Section 1.7, A.B. and C. where medically feasible, consultation shall occur prior to the contemplated therapy being implemented.

E. The requesting Practitioner shall request consults in the order section of the EMR and also document in the consultation request form the type of consult (as described in paragraphs I. 1-3 below) and the reason for the consult. It is the responsibility of the requesting Practitioner to indicate in the orders the type of consult (routine or emergent – see below paragraphs) and the reason for the consult. The requesting Practitioner shall contact the consultant Practitioner

directly, relaying necessary information including expectations as to timeframe for the consult to take place. This information shall be documented in the electronic medical record.

1. Routine Consultations: Routine consultations shall be performed within twenty-four (24) hours of the consultation order or consistent with such other appropriate care plan as documented on the consultation request form and mutually agreed to between the requesting Practitioner and the consulting Practitioner. The requesting Practitioner must make direct Practitioner to Practitioner contact with the consulting Practitioner.

2. Emergent Consultations: Emergent consultations are those consultations the requesting Practitioner determines need to be performed sooner than twenty-four (24) hours. The requesting Practitioner must make direct Practitioner to Practitioner contact with the consulting Practitioner.

F. Medical Staff Appointees shall respond to requests for inpatient consultations in the time frame determined at the time of the consult request. If the consultant is unable to respond within the timeframes specified, the consultant will contact the requesting Practitioner to arrange a mutually satisfactory care plan.

G. A consultation shall be obtained on a surgical patient not already under the active care of an Internist, Hospitalist, or Family Physician who is transferred to ICU for medical reasons and for medical treatment.

H. Consultations will be required in appropriate cases as specified pursuant to Hospital policy.

I. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be documented in the electronic medical record at the time it is performed. If the report is dictated, there is to be a notation made in the electronic medical record signifying this dictation, and a brief summary. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

1. When "Consultation Only" is requested, the consultant will evaluate the patient, rendering an opinion and recommendations, but may not initiate orders in the electronic medical record or otherwise participate in the care of the patient.

2. When "Consult and Co-Manage" is requested, both the attending Practitioner and consultant may initiate orders. The consultant will limit involvement to the specific entity or procedure requested. Responsibility for other management remains with the attending Practitioner. The co-managing Practitioner is responsible to see the patient daily unless the co-managing Practitioner indicates otherwise as documented in the progress note.

3. Unless the requesting Practitioner documents otherwise on the consult request form, it is presumed that all consult requests are for "Consult and Co-Manage."

J. When the Anesthesia Department determines that a medical consult is needed, the attending surgeon should be requested to order a medical consult from an Appointee of the Clinton Memorial Hospital Medical Staff, e.g., patients with multiple medical problems or those on multiple medications and who do not have a family Practitioner/APP on the Staff.

SECTION 1.8 CONTINUITY OF CARE

A. Every Active and Courtesy Staff Appointee of the Medical Staff shall ensure the availability of adequate professional care for their patients who are admitted to the Hospital or who may present to the Hospital by being readily available or by having available an alternative Practitioner on Staff with comparable Privileges with whom prior arrangements have been prepared. Notification of alternate Appointee coverage shall be made directly to the Hospital paging service or alternatively through the submission of a mutually agreeable call schedule. For Medical Staff specialties in which there is only one Practitioner with Clinical Privileges in such specialty and consequently no alternate coverage is available, then such single specialty may name as back up a Practitioner with comparable privileges at another hospital. In the event of failure to name an alternate Practitioner, the CEO of the Hospital shall have authority to call the Director of Medicine or the Director of Surgery if necessary. In the event the appropriate Director is unavailable, the Chief of Staff will be contacted to provide for coverage. Failure to provide adequate alternative Practitioner coverage is a failure of meeting baseline criteria for Medical Staff appointment. In addition, the incident(s) may be referred to the Medical Staff Quality Improvement Committee and Peer Support Committee.

B. Each attending Practitioner must ensure that inpatients and observation patients are seen on a daily basis; provided, however, continuity of care for patients admitted to any sub-acute unit shall be in accordance with the policies and procedures for such unit. If the attending Practitioner is unable to see the patient in accordance with the applicable requirement, the attending Practitioner shall make arrangements for another Appointee on the Medical Staff to follow-up in their absence. An APP cannot be solely responsible for the patient. The attending Practitioner is responsible unless there has been explicit transfer of care to another Practitioner who has agreed to assume care of the patient.

C. Continuity of Care for Patient Admitted from Emergency Services:

1. Recommend Admissions:

a) It shall be the responsibility of the on-duty Emergency Medicine Practitioner/APP to communicate the medical status to the attending Practitioner.

b) It shall be the attending Practitioner's decision to admit. If there is a disagreement between the attending Practitioner and the Emergency Medicine Practitioner/APP, the attending Practitioner is expected to come in and examine the patient in question.

c) The responsibility for the care of the patient shall be that of the attending Practitioner when the Medical Staff Appointee accepts the patient.

d) The attending Practitioner shall examine the patient when medically appropriate.

e) The Emergency Medicine Practitioner/APP will be available for additional emergency care if needed.

f) Patients accepted in transfer from another facility by an attending Practitioner with admitting Privileges shall be seen by the attending Practitioner as an outpatient, as a direct admission or assignment to observation, at an appropriate time. A Practitioner who accepts the transfer of a patient is responsible for the care of the patient.

2. Documentation:

a) It shall be the responsibility of the on-duty Emergency Medicine Practitioner/APP to make notation on the Emergency Services record of their discussion with the attending Practitioner.

b) If the Emergency Medicine Practitioner initiates the admitting orders, the first line in the orders should say "Admit to Dr. (attending Practitioner)" and they shall be co-signed by the attending Practitioner.

D. Continuity of Care for Patients Transferred from another Facility

1) The attending Practitioner who has accepted the transfer of a patient from another facility shall have the responsibility to arrange the direct admission of the transferred patient into the Hospital by contacting the Hospital's "Transfer Center."

2) If the accepting attending Practitioner displaces the transferred patient to the Emergency Department; then the accepting attending Practitioner will adhere to the established Hospital policy on transferred patients from another facility.

SECTION 1.9 PATIENT CARE HOSPITAL ORDERS

1.9-1 Requirements

A. Orders for medication or treatment shall be entered in the electronic medical record and shall be signed by the authorized prescriber giving the order.

B. Texting patient orders to hospital personnel is prohibited.

C. All orders for drugs shall include, but not be limited to:

1. the name of the patient,
2. the name, exact strength, concentration (when applicable) and dosage form of the drug,
3. the directions for use, including route of administration, dose and frequency, and the quantity and/or duration, when applicable,
4. the date and time prescribed,
5. the prescriber's identification, and
6. Medication Reconciliation form shall be utilized per Hospital policy.

D. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or, as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist), another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; current or potential impact as indicated by laboratory values; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. After the medication order has been reviewed, all concerns, issues, or questions must be clarified with the individual prescriber before dispensing.

E. When the patient brings their medication(s) to the hospital, those medications which are clearly identified may be administered by the nursing staff only if ordered by the Practitioner/APP and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient.

1.9-2 Preprinted Orders

When documenting orders, Practitioners may use order sets which have been developed and approved and are subject to periodic review in accordance with Hospital policy. An order set is a patient-specific definitive set of drug treatment directives to be administered to an individual patient who has been examined by the prescriber and for whom the prescriber has determined that the drug therapy is safe and appropriate when used pursuant to the conditions set forth in the order set. An order set may be developed by an individual Practitioner or group solely for their practice or it may be developed for a drug order that is commonly used by many different Practitioners. Under either instance, upon

first creation, all order sets shall be submitted by the initiating Practitioner(s) to their relevant Department Director for review. The Department Director has discretion to revise the order set or to seek input from the relevant Department Committee, or selected members thereof, as the Director determines appropriate in their sole discretion.

1.9-3 Verbal Orders

A. All verbal orders shall be transmitted by the Practitioner to a licensed practical nurse, registered nurse or APP.

B. The licensed practical nurse, registered nurse or APP is authorized to receive the order and enter it onto the appropriate Practitioner's order sheet. The order shall be read back to the Practitioner by the LPN/RN/APP to verify accuracy. The Practitioner may request the orders be faxed to them for verification assuming the responsibility for a timely return. A licensed nurse will retain the prerogative to refuse to take an order from the Practitioner and must document the basis for such refusal. Nursing action shall be in accordance with Hospital policy. All verbal orders must be signed by the individual receiving the order. The identity of the Practitioner must be established prior to accepting a verbal order.

C. Verbal orders should be used rarely and with caution because of the risk of error.

D. All verbal orders must be authenticated by the ordering Practitioner in a timely manner but not to exceed thirty (30) days after the order is given. Authentication of the verbal order requires the Practitioner to verify, sign, date, and time the order. For all verbal orders, if the prescribing Practitioner is reasonably unavailable to countersign the verbal order within the required timeframe, the covering Practitioner may countersign so long as the order is within the scope of the covering Practitioner's Privileges.

Countersignature by the covering Practitioner indicates that the covering Practitioner assumes responsibility for the order being complete, accurate, and final.

1.9-4 Order Stops

Except for sub-acute and rehab patients, all Practitioner orders for drugs and biologicals without specific limitations as to time or number of doses shall be stopped at seven (7) days, unless otherwise reordered upon review. On day six, the attending Practitioner will be requested to review.

1.9-5 Resident Physicians

Resident physicians may only enter orders for treatment at the sole discretion and responsibility of the Medical Staff Appointee responsible for the patient's care. Resident verbal orders require countersignature by the supervising Physician.

Resident Physicians of other institutions may only function in the hospital when there is an appropriate agreement with scope of service signed between Clinton Memorial Hospital and the Residency Program.

1.9-6 Orders from non CMH Medical Staff Practitioners/APP's

A. Orders for therapeutic services that require the administration of medications must be provided by a Medical Staff member with appropriate credentials and privileges.

B. Diagnostic and therapeutic reports will be forwarded to the ordering Practitioner/APP to interpret the results of the tests, treatments, or procedures and inform the patient as appropriate.

C. Notwithstanding paragraph 1.9-3(D) above, verbal telephone orders for outpatient radiology, laboratory and ambulatory care clinic procedures or treatment shall be performed only after receipt of the non-Staff Practitioner's/APP's written order except in an emergency.

D. It shall be the responsibility of the outpatient/ancillary department to ensure that a process is in place to: ensure Practitioner/APP state licensure and Medicare/Medicaid eligibility, obtain appropriate authentication of all such orders before carrying them out, and confirm the Practitioner/APP is not listed on the OIG sanctions website. The ordering Practitioner/APP must provide contact information where they can be reached when the service is provided. Each department shall develop appropriate policies and procedures on the process.

SECTION 1.10 RESTRAINTS

Restraints shall be applied in accordance with Hospital policy.

SECTION 1.11 SECOND OPINIONS

Second opinions shall be obtained when requested by the patient or the patient's insurance carrier.

SECTION 1.12 PATIENT DEATHS

1.12-1 Autopsies

Every Appointee of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper written consent. All autopsies shall be performed by a Physician delegated this responsibility.

A. Autopsy Criteria:

The Medical Staff and other appropriate Hospital staff shall use the following criteria to identify deaths for which an autopsy should be considered.

1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.

2. Deaths in which the cause is not known with certainty on clinical grounds.

3. Cases in which an autopsy may help allay concerns of the family and / or the public regarding the death, and provide reassurance to them regarding the same.

4. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedure and/or therapy.

5. Deaths occurring to patients who have participated in clinical trials (protocols) approved by institutional review boards.

6. Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

7. Natural deaths that are subject to, but waived by a forensic jurisdiction such as the following:

    a. Persons dead on arrival at the Hospital.

    b. Death occurring in the Hospital within 24 hours of admission.

    c. Deaths in which the patient sustained or apparently sustained an injury while hospitalized.

    d. Deaths resulting from high-risk infectious and contagious diseases.

8. All obstetric deaths.

9. All neonatal and pediatric deaths.

10. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.

11. Deaths known or suspected to have resulted from environmental or occupational hazards.

B. Autopsy Scheduling:

Autopsy services are not provided at Clinton Memorial Hospital but are offered via a contracted service. Refer to current CMH "Autopsy Postmortem Examination."

1.12-2 Coroner's Cases

For notification of Coroner and definition of Coroner's Cases refer to Hospital policy "Coroner Case".

1.12-3 Determination of Death

The Guidelines for Determination of Death shall be as outlined in the Ohio Revised Code 2108.40 and Hospital policy named, "Death-Pronouncement of and Postmortem Care of the Body."

ARTICLE II: CLINICAL SERVICES AND UNITS

SECTION 2.1 ANESTHESIA AND SEDATION POLICIES

A. There shall be a pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services. In addition, there shall be a pre-anesthesia or pre-sedation assessment of the patient immediately before beginning moderate or deep sedation or anesthesia induction, as applicable.

B. For all surgeries and procedures requiring anesthesia, including moderate sedation, the patient's post procedure status is assessed on admission to and before discharge from the post-sedation or post-anesthesia recovery area. Medical Staff approved discharge criteria may be utilized for determining discharge status.

C. In addition, for all inpatients, a post anesthesia assessment/note which describes the presence or absence of anesthesia complications shall be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery or procedure requiring anesthesia.

SECTION 2.2 EMERGENCY SERVICES

A. The Hospital shall provide a method of medical coverage in the Emergency Department or other appropriate Hospital area whereby all ill or injured individuals who come to the Hospital for emergency medical evaluation or initial treatment are assessed by qualified individuals and, as indicated, either treated or referred to an appropriate facility. This shall be in accordance with the CMH EMTALA policy for the delivery of such services, including the delineation of Clinical Privileges for all Medical Staff Appointees who render emergency care and other Appointees required to provide call coverage.

B. All Appointees of the Active and Courtesy Staff are on mandatory call for their respective services for the evaluation and treatment, including any necessary follow-up care, of Hospital patients with potential emergency medical conditions and acceptance of new patients on referral when they have no local Practitioner and need to be hospitalized from the Emergency/Outpatient Services Departments.

C. For purposes of the Emergency Medical Treatment and Labor Act (EMTALA), registered nurses working on the Mother Baby Care Unit are designated as qualified medical personnel under EMTALA who are qualified to provide initial medical screening examinations for patients presenting to the Hospital consistent with obstetrical triaging policies approved by the Mother Baby Care Committee.

D. Screening

1. Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

2. Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.

3. All patients shall be examined by a Practitioner, physician assistant or advanced practice nurse with privileges to conduct screening examinations at the Hospital, or in the case of a woman in labor, a registered nurse trained in obstetric nursing pursuant to Hospital policy, Medicare and other applicable federal regulations.

4. Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

E. Stabilization

1. Any individual experiencing an emergency medical condition must be stabilized prior to transfer to an inpatient unit, other facility, or discharge home, excepting conditions set forth below.

2. A patient is Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating Practitioner/APP has provided written documentation of their findings.

3. A patient is Stable for Transfer if the treating Practitioner/APP has determined, within reasonable clinical confidence, that the patient is

expected to leave the Hospital and be received at a second facility, with no material deterioration in their medical condition; and the treating Practitioner/APP reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when they are protected and prevented from injuring themselves or others.

4. A patient does not have to be stabilized when:
   (i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or
   (ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a Practitioner/APP signs a certification which includes a summary of risks and benefits to this effect.

5. If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Practitioner/APP, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that they refused the treatment. The Emergency Department Practitioner/APP shall document the patient's refusal in the patient's electronic medical record, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a Practitioner/APP for outpatient follow-up care.

F. Transfer

1. The Emergency Department Practitioner/APP shall follow the hospital's transfer policy in all patient transfers in order to ensure the consent of the receiving hospital facility is obtained before the transfer of an individual, and that appropriate arrangements are made for the patient transfer with the receiving hospital.

2. The condition of each transferred individual shall be documented in the medical records by the Practitioner/APP responsible for providing the medical screening examination and stabilizing treatment.

3. Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call Practitioner (or designee) who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

4. All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Practitioner/APP must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

G. Consultations, Referrals & Emergency Department Call

1. When the Emergency Department Practitioner/APP determines that a consultation or specialized treatment beyond the capability of the Emergency Department Practitioner/APP is needed, the patient shall be permitted to request the services of a specific private Practitioner/APP. This request will be documented in the patient's medical record.

2. The Practitioner/APP whom the patient requests shall be contacted by the Emergency Department Practitioner/APP and that person will document the time of the contact in the patient's medical record.

3. An appropriate attempt to contact the On-Call Practitioner or their On-Call designated APP will be considered to have been made when the Emergency Department Practitioner/APP has:

    a. Contacted the Practitioner/APP through PerfectServe (or equivalent);
    b. Called the Practitioner/APP at home;
    c. Called the Practitioner/APP at their office; and
    d. Called once on the Practitioner/APP's cell phone.

    Twenty minutes will be considered a reasonable time to carry out this procedure.

4. The rotation call list, containing the names and contact information of the on-call Practitioners/APPs shall be posted on the intranet. In the event that the patient does not have a private Practitioner/APP, the private Practitioner/APP refuses the patient's request to come to the Emergency Department, or the Practitioner/APP cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private Practitioner/APP to provide the necessary consultation or treatment for the patient. A Practitioner/APP who has been called from the rotation list may not refuse to respond. The Emergency Department Practitioner/APP shall determine whether the on-call Practitioner/APP is required to come in to personally assess the patient. Any such refusal shall be reported to the Department of Medicine Director, Department of Surgery Director and/or Chief of Staff and/or their respective designee for further action and may constitute grounds for revocation of the Physician's/APP's Medical Staff appointment and/or clinical privileges.

5. The Practitioner/APP called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that Practitioner/APP is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the Practitioner's/APP's office. If, after examining the patient, the Practitioner/APP who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that Practitioner's/APP's responsibility to make the second referral. The first Practitioner/APP consulted retains responsibility for the patient until the second consultant accepts the patient.

6. All members of the Active Staff and Courtesy Staff shall participate in the on-call backup to the Emergency Department.

   On- Call Practitioner's or their designated On-Call APP called are required to respond to Emergency Department call by telephone within twenty (20) minutes. If requested to come in, they are required to do so within a reasonable time not to exceed sixty (60) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within twenty (20) minutes of initial contact.

7. The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written Hospital policy.

SECTION 2.3 INTENSIVE CARE UNIT

A. Refer to Hospital policy "Intensive Care Unit Scope of Services," for ICU Admission and Discharge Criteria.

B. In the event ICU is completely occupied and there is a need to admit another critical patient in an emergency situation, the attending Practitioner of a potential patient transfer off the unit should be consulted. In the event the attending Practitioner is not available, the Physician Advisor of ICU has the authority to transfer ICU patients off the unit. In the event neither the attending Practitioner nor the Physician Advisor of the ICU is available, the Director of Medicine will be responsible for this action. If, in the judgment of this latter Practitioner, none of the patients can be transferred off the unit, the new patient should be held in Emergency Services, or transferred to another hospital or admitted to Telemetry as appropriate.

C. Unless otherwise stated by the attending Practitioner, all orders are discontinued on transferring a patient from or to the ICU.

D. An initial assessment of all patients in the intensive care/critical care unit must be performed no later than two (2) hours after admission or sooner if warranted by the patient's condition per CMH Bylaws (Article VI: Section 6.3-4)

SECTION 2.4 OBSTETRICS

A. Rules for visitors in the Labor Room will be in accordance with Hospital policy, "Patient Visitor Guidelines.".

B. STAT/Emergency Cesarean Sections: On- Call Obstetrician must remain on-site or be available to return to the Hospital and be prepared to perform a c-section within the ODH/ACOG decision to incision time requirements. On-Call Anesthesia personnel shall remain on-site or be available to return to the Hospital with enough time to administer adequate anesthesia prior to incision, in which the incision must occur within the ODH/ACOG decision to incision time requirements. Refer to Hospital Policy, "Cesarean Sections Performed in the Obstetrical Department Policy.

C. Although not required, upon the request of the delivering obstetrician or Practitioner/APP with OB privileges, a pediatrician (or if not available, an appropriately credentialed Practitioner/APP with pediatric privileges) will be present at all deliveries, including but not limited to non-elective C-Section deliveries or in the event of unavoidable delivery of a high-risk patient, or unexpected fetal or neonatal distress.

D. At all deliveries, qualified hospital staff skilled in neonatal resuscitation will be available to care for the infant and present in the delivery room upon delivery.

E. All Practitioners/APPs currently providing obstetrical services will be placed on the OB Walk In Call List for unattached patients. If a Family Practice Physician should determine the patient to be high risk, they should then refer to an OB/GYN

F. Prior to induction by medication is used, a Practitioner with C-Section Privileges shall be notified.

G. Elective deliveries will not be scheduled on weekends or holidays, unless arrangements are made in advance with the OB administrator or their designee.

SECTION 2.5 SURGERY

2.5-1 History & Physical

Prior to all surgeries or any procedure requiring anesthesia services (including moderate sedation), whether inpatient or non-inpatient service, the patient's complete history and physical, any indicated diagnostic tests, and a preoperative diagnosis must be completed and documented in the electronic medical record before any surgery can start. In any emergency, when there is no time to record the complete history and physical examination,

a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery.

The history and physical may be performed within 30 days prior to admission or registration; provided, however, in the event a history and physical examination was not performed within 30 days prior to admission or registration, an updated examination, for changes to the patient's condition, must be completed and documented within 24 hours after admission/registration, but in all circumstances must be performed prior to surgery or procedure requiring anesthesia.

2.5-2 Consent

The responsible surgeon prior to the operative procedure except in emergencies shall obtain written, signed, informed, surgical consent as described in Article III: Section 3.5.

2.5-3 Operative Report

All operations and procedures performed within the surgical services department (ie; surgical suites, endoscopy suite, Cath lab, interventional suite, c-section suite, etc) shall be fully described by the operating surgeon or proceduralist in the EMR, hand-written, or dictated immediately after surgery. The operative report shall include:

1. name and hospital identification number of the patient,
2. date of the surgery,
3. name of the specific surgical procedure(s) performed and their indications,
4. the name of the surgeon(s) and assistants or other persons who performed surgical tasks, and a description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner,
5. techniques, findings,
6. complications, if any,
7. technical procedures used,
8. type of anesthesia administered,
9. specimens removed or altered and prosthetic devices, grafts, tissues, transplants, or devices implanted, if any,
10. pre-operative and postoperative diagnosis,
11. estimated blood loss.

A handwritten operative progress note is required immediately after surgery when the operative report is dictated on the 3rd party hospital dictation system (ie, Emon or equivalent) or when the operative report is not completed in the EMR immediately after surgery.

An operative progress note shall include operative report information, including date and time, names, findings, technical procedures used, specimens removed, and postoperative diagnosis, and estimated blood loss. For purposes of this paragraph, "immediately after surgery" means upon completion of surgery and before the patient is transferred to the next

level of care. If the surgeon accompanies the patient from the operating room to the next unit or area of care, the note can be documented in that unit or area of care.

2.5-4 Use of Surgical Assistant

When deemed appropriate in the judgment of the operating surgeon, a qualified assistant will be present for the procedure. A qualified assistant shall be one approved by the surgery staff whose demonstrated competence has qualified them for this position. The name of the assistant should be documented on the operative note.

2.5-5 Sterilizations

For all sterilizations involving Medicaid patients, please refer to the guidelines in the Ohio Revised Code (ORC) 5160-21-02.2.

2.5-6 Physical Status III, IV, or V

Those patients having surgery and classified, per the American Society of Anesthesiologists, as Physical Status III, IV, or V must be evaluated by the Primary Care Practitioner/APP or Internist prior to surgery and documented in the electronic medical record, except by the prerogative of the surgeon as defined in Hospital policy, "Preoperative Evaluation/ Risk Assessment of Elective Surgery Patients."

2.5-7 Organ & Tissue Donation

The medical staff participates with the hospital in developing and implementing written policies and procedures for the donation and procurement of organs and tissues, as required to comply with applicable federal law and accreditation standards.

ARTICLE III: MEDICAL RECORDS

SECTION 3.1 OWNERSHIP AND ACCESS

Medical Records created and maintained in paper format at the hospital or hospital owned physician offices or clinics may not be removed in their original state from the facility in which they are stored and maintained unless mandated by law or upon written approval of the CEO.

Appointees shall be permitted access to the medical records of their patients for the treatment of such patients as permitted by law. Former Appointees of the Medical Staff may be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital as permitted by law. All other disclosures of medical records shall be in accordance with federal and state law and the Hospital's Notice of Privacy Practices.

SECTION 3.2 ADMISSION H&P

3.2-1 Requirement

The attending Practitioner shall be responsible for performing a complete history and physical examination for each patient admitted to the Hospital or assigned to observation status. In all cases the admission H&P shall be performed and documented in the electronic medical record or dictated and placed in the electronic medical record within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services.

If the complete H& P was performed within 30 days prior to admission, the H&P may be used but there must be a medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services.

The H&P must be performed by a Practitioner with Clinical Privileges at Clinton Memorial Hospital. However, an H&P performed by a Practitioner who is not an Appointee, Practitioner with Privileges or an APP at the Hospital must be countersigned (and dated) by the admitting Practitioner or responsible surgeon. The admitting Practitioner or responsible surgeon must review the H&P, conduct a second assessment to confirm the assessment, update any findings as necessary, including a summary of the patient's condition and course of care during the interim period, noting the patient's current physical / psychosocial status and signs and dates the information as an attestation to it being current. The second assessment must be completed and documented within 24 hours of the patient's admission, but prior to surgery or a procedure requiring anesthesia services.

3.2-2 Definition of Complete History and Physical Documentation (reference CMH Medical Staff Bylaws, Article VI Section 6.3-4)

A complete H&P at minimum must contain an age specific assessment of the patient including: (a) the chief complaint, which is a statement that establishes medical necessity

in concise manner based upon the patient's own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over- the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and (k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

3.2-3 Failure to Perform/Document H&P

If a History and Physical is not in the hospital designated electronic medical record within twenty-four hours from time of admission or assignment to observation, direct notification of the responsible Practitioner will be initiated. If the History and Physical is not completed at forty-eight (48) hours after admission, all further admission Privileges shall be suspended until its completion.

SECTION 3.3 COMPLETION OF MEDICAL RECORDS

A. The attending Practitioner/APP shall be responsible for the preparation of a complete medical record for each patient. A complete medical record is defined as: its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge; its contents, including any required clinical resume or final progress notes, are assembled and authenticated; and all final diagnoses and complications are recorded without the use of symbols or abbreviations. The medical record must be completed within 30 days of the patient's discharge.

B. Incomplete medical records are tracked by the medical records department. Incomplete medical records' listing is updated at midnight each day. After patient discharge and conversion of the record to electronic format, Practitioners/APPs complete all deficiencies via the electronic medical record system.

C. Practitioners/APPs receive a first warning letter (via email, text, or facsimile as requested by Practitioner to Medical Staff Services upon appointment or reappointment, as applicable) for all medical records that are incomplete at fourteen (14) or more days after patient discharge. A complete listing of their incomplete medical records is sent with the warning letter.

D. Practitioners/APPs receive a second warning letter for all medical records that are incomplete at twenty-one (21) days after patient discharge. A complete listing of their incomplete medical records is sent with the second warning letter.

E. In addition to the second warning letter, Practitioner/APP receives a phone call from Medical Records Manager or designee regarding records that are incomplete at twenty-one (21) days after patient discharge. The call will be made to the Practitioner's/APP's designated Perfect Serve number and message left if the Practitioner/APP does not immediately answer. The Practitioner/APP is responsible for making arrangements to complete their records.

F. Suspension process is implemented if the medical record is not complete at thirty (30) days after the patient's discharge.

G. Suspensions occurring during a Practitioner's/APPs absence from the Hospital as a result of illness or scheduled vacation or other good cause shall be delayed until the Practitioner's return.

H. Suspension of admitting privileges is defined as inpatients, outpatients, Emergency Services patients and consultations; except with respect to previously scheduled procedures and patients previously admitted prior to the suspension.

I. Suspensions lasting seven days will be escalated to the Department Chair and the Chief of Staff.

SECTION 3.4 DOCUMENTATION REQUIREMENTS

3.4-1 Continued Hospitalization

The attending Practitioner is required to document all clinical entries in the electronic medical record, including the need for continued hospitalization after specific periods of stay in collaboration with the Care Management Program. This documentation must contain:

A. An adequate entry in the electronic medical record of the reason for admission and continued stay in the Hospital.

B. Discharge planning (estimated days of continued care and plans for post-op care) in collaboration with Care Management.

C. In the event that paper records are used, they shall be legible, accurately dated, timed, and authenticated.

D. Unapproved symbols and abbreviations as defined by the Joint Commission may not be used in the medical record.

E. The principal and any applicable secondary diagnosis, complications and procedures should be recorded in the electronic medical record at or about the time of discharge by the attending Practitioner or their designated APP.

3.4-2 Discharge Summary

A. A discharge summary shall be entered into the electronic medical record on all medical records of patients stays of 48 hours or more and shall contain the reason for hospitalization, principal and other relevant diagnoses, significant findings, procedures performed and treatment rendered, the patient's condition at discharge, and instructions to the patient and family, if any. The condition at discharge should be stated in terms that permit a specific measurable comparison with the condition upon admission.

For patients with hospital stays of less than 48 hours (including observation patients), a final progress note may be substituted for the discharge summary. Such a note shall be signed, dated, and timed and shall document the patient's condition at discharge, discharge instructions, outcome of hospitalization, disposition of the case, and required follow-up care.

B. If a patient is transferred within the Hospital from one level of care to another (i.e. ICU to 3 Tower) and the caregivers change, a transfer summary may be used instead of a discharge summary. The transfer summary shall describe the patient's condition at the time of transfer and the reason for the transfer. If the caregivers remain the same, a progress note may suffice.

C. The attending Practitioner at the time of discharge is responsible for the discharge/transfer summary unless another Practitioner is consulted and explicitly assumes transfer of the care of the patient as documented in the Medical Record.

D. All discharge summaries and final notes are highly encouraged to be completed upon discharge but in all cases discharge summaries must be completed within seven (7) days following discharge. The failure to timely complete discharge summary shall be treated as a failure to timely complete medical records.

3.4-3 Signature Stamps

Signature stamps are not permitted as a substitute for signature or electronic signature and may not be used as authentication of signature.

SECTION 3.5 INFORMED CONSENT

Except in emergencies, written informed consent must be obtained by the responsible Practitioner and the consent added to the patient's medical record prior to all major and minor surgical procedures and all endoscopic procedures (e.g. bronchoscopies, gastroscopies, cystoscopies, colonoscopies, flexible sigmoidoscopies) prior to performing the procedure. All consents must be obtained within thirty days of the procedure. Written informed consent shall be obtained for the

following procedures requiring invasion of body tissues: spinal taps, paracentesis, thoracentesis, swan-ganz catheter, pacemaker insertion, bone marrow, amniocentesis, tissue biopsy (lung, kidney, liver, etc.), pulmonary wedge monitor, arthrogram.

The written consent form shall include:

1. the identity of the patient,
2. the responsible Practitioner,
3. the procedure,
4. reasonably known risks, benefits, and alternatives, and
5. a statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative;
6. signature of the patient or surrogate decision-maker signature, and
7. date and time the informed consent form is signed by the patient or the patient's legal representative.
8. signature, dated and timed, of the Practitioner performing the procedure.

In addition, for surgical procedures, when reasonably known in advance, the consent form should also identify the name of the Practitioners other than the primary surgeon who will be performing significant surgical tasks (such as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissue).

It is the Practitioner's responsibility to explain the procedure, risks, and alternatives to the patient, however, a registered nurse may assist in obtaining patient acknowledgement and completing the form pursuant to Hospital policy after the Practitioner has obtained the informed consent. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from patients, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken.

SECTION 3.6 PHARMACY AND THERAPEUTICS

3.6-1 General

Only a licensed Practitioner/APP with a valid current certificate to prescribe may prescribe drugs.

3.6-2 Formulary

Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-official Drugs, American Hospital Formulary Service, and American Medical Association Drug Evaluations with the exception of drugs from approved clinical investigations. Exceptions to this rule shall conform to generally accepted standards of care. Practitioners and APPs shall adhere to all formulary decisions approved by the Pharmacy and Therapeutics Committee and the Department of Medicine and/or the Department of Surgery as appropriate.

3.6-3 PRN Orders

All PRN orders shall state the dosing interval and the clinical indication for the order. (For example: "PRN" is prohibited, but "q 2 hours PRN pain" is permissible.)

3.6-4 Dosing Symbols & Decimal Points

1. The symbol "U" shall not be used for "units." The word "units" shall be spelled out.
2. The symbol "μ" shall not be used for "micrograms." The symbol "mcg" may be used.
3. For whole numbers, a trailing "0" shall never be written after a decimal point. (Ex. "4.0" is prohibited but "4.02" is permissible.)
4. For dosing amounts less than one, a leading "0" is required in all instances before the decimal point. (Ex. "0.2").

3.6-5 Blanket Orders

The use of blanket orders for medications ("continue previous meds," "resume preoperative meds," "resume meds from home," or "discharge on current meds"), without reference to a prior or specific medication order(s) in the electronic medical record, is prohibited.

SECTION 3.7 PROGRESS NOTES

3.7-1 Admitting Note

All inpatient/observation cases shall have an initial progress note documented in the electronic medical record within 24 hours of admission, stating the reason for admission, impression, and the plan of treatment or kind of surgery that is expected to be carried out.

3.7-2 Daily Progress Notes

All inpatients and patients assigned to observation status must have a daily progress note (See Article III: Section 3.3A Medical Records). These progress notes will:

A. Accurately reflect the patient's condition.

B. Indicate the need for continued care as required by the Staff approved Utilization Review Plan.

C. Give reasons for any change in treatment planning, including changes in medication, patient activities and Nursing care orders, as well as reasons for repeating Laboratory, X-ray or special procedures.

D. Changes of patient from observation to inpatient must be documented in the Medical Record to indicate the reasons.

3.7-3 Surgical Cases

Surgical Cases shall have:

A. A progress note by the surgeon, prior to surgery, which articulates condition of the patient and the expected surgical procedure.

B. A History and Physical in accordance with the Medical Staff Bylaws and/or Rules and Regulations.

C. In life threatening situations, paragraphs A. and B. above may be waived until the patient has been stabilized.

D. A surgical consent form must be completed before the procedure and is valid for 30 days after execution of the consent.

E. An operative note pursuant to Article II: Section 2.5-3 shall be completed and documented in the electronic medical record, and shall include the findings at the operation and the surgery performed.

F. A daily progress note by the surgeon reflecting any changes in condition or treatment of patient until the post-operative condition of the patient is stable or the patient has returned to the care of the attending Practitioner.

3.7-4 Anesthesia Notes

Policies for progress notes documented by the anesthesiologist or anesthetist are set forth in Article II: Section 2.1 of these Rules and Regulations.

3.7-5 Special Procedures

A progress/procedure note shall be documented by the responsible Practitioner/APP immediately after performing special procedures outside of the surgical services department such as: Endoscopy of any kind, a chest or abdominal tap, etc., noting essential information about the procedures and describing the presence or absence of anesthesia complications, if applicable. Also, additional information pertinent to the physical examination such as delayed rectal or pelvic examination will be added to the record as a progress note.

3.7-6 Incident Cases

The responsible Practitioner/APP shall document a progress note at any time they are called to see their patient because of an unforeseen incident.

3.7-7 All Cases

All progress notes shall be dated, timed and signed.

3.7-8 Blood Utilization

A progress note or the transfusion order form shall be documented by the attending Practitioner/APP documenting the indications for the transfusion. Reasons for premature termination of transfusion and any transfusion reaction must be documented in the progress notes. Except in emergency situations, the Practitioner/APP shall obtain the patient's informed consent to blood/blood products, as documented in a written consent form or in the Practitioner's/APPs progress notes.

3.7-9 Failure to Complete Progress Notes

If a medical record shows that progress notes are not in compliance with the guidelines set forth in these Rules and Regulations in Article III: Section 3.7, the responsible Practitioner/APP will be so notified. If the documentation of progress notes has not been brought into compliance by the end of one (1) working day after notification further admissions or assignments to observation will be suspended until compliance has been accomplished by the responsible Practitioner/APP.

ARTICLE IV: REFERRALS

SECTION 4.1 REFERRALS TO CASE MANAGEMENT/SOCIAL SERVICES

To accommodate early intervention with patient/families in need of discharge planning services; there shall be open referrals to Case Management/Social Services. The procedure shall be as outlined in the Care Management Department Scope of Assessment and Scope of Service.

SECTION 4.2 REFERRALS FOR SERVICES NOT AVAILABLE AT CMH

In the event that special services not currently available at CMH are needed for the management of a patient's particular medical problem or disease, arrangements will be made for referral to an accredited institution or consultant by the attending Practitioner with the approval of the patient and family, e.g., high technological diagnostic or therapeutic equipment, bone marrow or other organ transplants, etc.

SECTION 4.3 RESIDENT PHYSICIANS - SUPERVISION OF

Generally, all aspects of patient care provided by the Resident are the responsibility of the supervising Practitioner. Supervising Practitioners must see inpatients and review the electronic medical record daily, co-sign all Resident progress notes, and document a comprehensive progress note at least once daily.

SECTION 4.4 APP STUDENTS- SUPERVISION OF

Generally, all aspects of patient care provided by the APP Student are the responsibility of the supervising Practitioner/APP in accordance with the Standard Care Agreement/Supervision Agreement.

ARTICLE V: ADOPTION AND AMENDMENTS

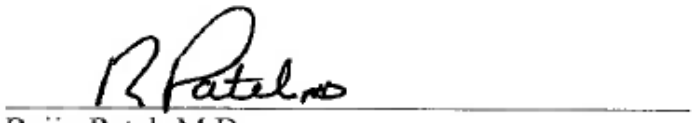
SECTION 5.1 ADOPTION & AMENDMENTS

These Rules & Regulations shall be adopted and amended as provided for in the Bylaws.

SECTION 5.2 RECOMMENDATIONS

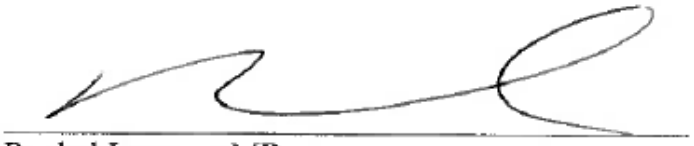
A committee appointed by the Chief of Staff shall be responsible for review of these Rules and Regulations no less than on a biennial basis, or more frequently if appropriate, and make recommendations to the Medical Executive Committee as to whether any amendments or revisions shall be enacted as approved for incorporation.

ADOPTED BY THE MEDICAL STAFF ON APRIL 18, 2025



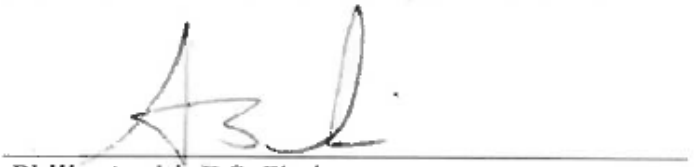
Rajiv Patel, M.D.
Chief of Staff

David Cohen, M.D.
Director of Medicine



Rachel Lovano, MD
Director of Surgery

APPROVED BY THE BOARD OF TRUSTEES ON APRIL 23, 2025



Philip Aschi, DO Chairman