Medical Staff Rules & Regulations

Bethesda Hospital

A Medical Staff Document

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ARTICLE I
DEFINITIONS

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

For purposes of this Policy, the term "House Staff" shall mean a physician-in-training providing patient care at the Hospital through a TriHealth or affiliated ACGME approved residency or fellowship program; or, a podiatrist-in-training providing patient care at the Hospital through a residency program approved by the American Podiatric Medical Association's Council on Podiatric Medical Education.

Words used in these Rules & Regulations shall be read as the masculine, feminine, or neuter gender, and as singular or plural, as the content requires. The headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Rules & Regulations.

ARTICLE II
ADMISSION

PART A: AUTHORIZED ADMISSIONS

A patient may be admitted to the Hospital by a Practitioner who has been granted admitting Privileges. The admission order shall indicate the patient class, either Inpatient, Observation, or Bedded Outpatient. If not self-entered by the Practitioner into the electronic medical record, the admission order can be given verbally and must be authenticated, dated, and timed by the admitting Practitioner or a covering Practitioner with admitting Privileges prior to discharge of the patient.

All patients require a diagnosis upon admission. If the Practitioner's documentation does not reflect the intensity of service or severity of illness, a request may be made to the admitting Practitioner to provide additional information.

Patients shall only be admitted for care, treatment, and/or services for which the Hospital has appropriate facilities and personnel. If the Hospital does not provide the care, treatment, and/or services needed by the patient, appropriate arrangements will be made for the necessary care, treatment, and/or services in an alternate facility so as not to jeopardize the health and safety of the patient.

Where the admission is by a Dentist or Podiatrist and the patient requires care, treatment, and/or services beyond the scope of the admitting Practitioner's license and Privileges, the admitting Dentist or Podiatrist is responsible for making arrangements with a consulting Physician Medical Staff Member with appropriate Privileges for such care, treatment, and/or services.

To the extent permitted by, and subject to, applicable laws, rules, and regulations and consistent with the scope of their current responsibilities within their residency/fellowship training program, House Staff may facilitate the admission process in consultation with the admitting Practitioner provided the admitting Practitioner approves and accepts responsibility for the admitting decision by authenticating/countersigning the admission order prior to the patient's discharge.

PART B: ADMITTER'S RESPONSIBILITIES

Each patient shall be the responsibility of the admitting Practitioner who shall act (or authorize a covering Practitioner with appropriate Privileges to act) as the attending Practitioner unless the care of the patient is otherwise transferred to a new attending Practitioner as set forth in Part D below.

The attending Practitioner shall be responsible for:

1. Providing medical (or other professional) care, treatment, and/or services within the scope of his or her license and Privileges.
2. Arranging for any necessary care, treatment, and/or services beyond the scope of his or her license and Privileges with a consulting Practitioner with appropriate Privileges.
3. Communication of the condition of the patient to the patient, the referring Practitioner (if any), and to the patient's authorized representatives (*e.g.,* legal guardian, family, *etc.*)

4. Participation in discharge planning.
5. Prompt, complete, and accurate documentation in the medical record.

PART C: ADMISSIONS FROM THE EMERGENCY DEPARTMENT

The admitting Practitioner shall have the responsibility of completing the admission orders on all patients admitted through the Emergency Department. The admission orders can be completed by one of the three options described below:

1. The admitting Practitioner will enter admission orders directly into the TriHealth Connect system. This is the preferred method of Practitioner order entry and is expected if the provider is in a TriHealth facility with TriHealth Connect access.

2. The admitting Practitioner will issue telephone verbal admission orders. Telephone verbal orders shall be accepted only when it is impractical for such orders to be directly entered into TriHealth Connect by the Practitioner. Telephone verbal orders will be given to Emergency Department nursing personnel (or another authorized individual) in accordance with the requirements set forth in TriHealth Corporate Policy 02_29.00 (Physician Orders: Verbal, Telephone, Faxed), as such policy may be amended from time to time.

3. In the event that direct entry of orders is not practical, and time does not permit the Practitioner to provide complete admission verbal orders via telephone, the admitting Practitioner may give a telephone verbal order to the nursing staff (or another authorized individual) to admit the patient and utilize the Basic/Quick Admission Order Set. It is the responsibility of the admitting Practitioner to thereafter complete the admission process within 24 hours.

PART D: TRANSFER OF RESPONSIBILITY

Whenever the attending Practitioner's responsibilities are transferred to another Medical Staff Member with appropriate Privileges, the new attending Practitioner must agree to the transfer and an order covering the transfer of responsibility shall be entered in the patient's medical record.

PART E: ALTERNATE COVERAGE

Practitioners shall assure the availability of adequate professional care for their patients in the Hospital. When unavailable, each Practitioner shall have made prior arrangements for the availability of an alternate covering Practitioner with Clinical Privileges at the Hospital sufficient to care for the absent Practitioner's patients. Failure to fulfill this requirement may result in corrective action.

PART F: "HAND-OFF COMMUNICATION"

When care is assumed by another Practitioner (*e.g.,* covering, consulting, new attending), Practitioners must communicate information regarding the patient's diagnosis, current condition, anticipated changes in condition, and recommendations. There must be an opportunity for the accepting Practitioner to ask questions regarding the information.

PART G: CRITICAL TEST VALUE COMMUNICATION

Critical test values shall be communicated in the manner set forth in TriHealth Corporate Policy 02_37.00 **(**Critical Results Reporting**)**, as such policy may be amended from time to time.

ARTICLE III
PATIENT RIGHTS

Patients are afforded those rights as provided for by applicable laws, rules, regulations, and accreditation standards as well as detailed in various TriHealth policies and procedures, as such policies and procedures may be amended from time to time.

PART A: INFORMED CONSENT

For information regarding obtaining and documenting informed consent, see TriHealth Corporate Policy #08_11.02 (Informed Consent and Consent Forms), as such policy may be amended from time to time. A list of procedures requiring informed consent, as such list may be amended from time to time, is set forth on the internal TriHealth intranet.

PART B: ADVANCE DIRECTIVES

Resources for clarification of Advance Directive questions include the Ethics Committee, TriHealth Risk Management, and TriHealth Corporate Counsel.

Section 1. Durable Power of Attorney for Health Care

For information regarding the Durable Power of Attorney for Health Care (also known as Health Care Power of Attorney), see TriHealth Corporate Policy #14_04.00 (Durable Power-of-Attorney for Health Care), as such policy may be amended from time to time.

Section 2. Living Will

For information regarding Living Wills, see TriHealth Corporate Policy #14_03.00 (Living Wills (Declarations) & the Non-Declarant Patient), as such policy may be amended from time to time.

Section 3. Code Status

For information regarding code status, see:

- TriHealth Corporate Policy #14_05.00 (Code Status Determination), as such policy may be amended from time to time.

- TriHealth Corporate Policy #02_34.00 (Withholding Resuscitative Services from Patients/Code Status Order), as such policy may be amended from time to time.

PART C: PATIENT RIGHTS MECHANISMS

Section 1. Ethical Issues

To be responsive to ethical issues that may arise in the course of treatment, the Hospital Ethics Committee is available, upon request, for consultation and support to facilitate discussion and decision-making. A Practitioner, APC, patient, family member, or employee may contact the

Ethics Committee through the Hospital operator. The Ethics Committee will first consult with the primary attending Practitioner.

Assistance with ethical issues may include:

a. Clarification of applicable policy.
b. Arranging a family conference.
c. Coordinating appropriate TriHealth resources (*e.g.,* Social Work, Pastoral Care, Risk Management, or Corporate Counsel).

Section 2. Use of Investigational Drugs, Devices, and Medical Research

The TriHealth Institutional Review Board (IRB) reviews and makes recommendations concerning all human research including investigational medical devices and procedures, as well as investigational drugs. The IRB assures, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of human subjects participating in research.

Gathering of data by retrospective chart review for any human research project requires prior approval from the IRB. By Federal Regulation 45 CFR 46, all human research (that is, a systematic investigation designed to develop or contribute to generalizable knowledge) at TriHealth facilities, including all research involving retrospective chart reviews, requires prior review and approval of the IRB.

Further detail and direction should be sought from the IRB, the TriHealth Hatton Research Institute, and TriHealth Corporate Policy #08_09.00 (Research, Human: Investigational Drugs, Devices & Procedures, TriHealth Institutional Review Board (IRB)), as such policy may be amended from time to time.

Section 3. Non Beneficial Care

When a conflict arises between a Practitioner and a patient (or the patient's authorized representative(s)) concerning provision of care that the Practitioner believes is non-beneficial, the Practitioner shall follow the procedure set forth in the TriHealth Corporate Policy #14_06.00 (Non-Beneficial Treatment), as such policy may be amended from time to time.

PART D: OUTCOMES INFORMATION

The attending Practitioner shall clearly explain to the patient (and, when appropriate, the patient's authorized representative(s)) the outcome of any care, treatment, and/or services provided to the patient to include information regarding outcomes that differ significantly from the anticipated outcomes. For additional information, see TriHealth Corporate Policy #08_02.00 (Disclosure of Patient Outcomes Policy), as such policy may be amended from time to time.

PART E: CONFIDENTIALITY

Practitioners, APCs, and House Staff have a duty to maintain patient confidentiality and therefore, generally, may not disclose any medical information revealed by a patient or discovered by a Practitioner, APC, or House Staff in connection with care, treatment, and/or services provided to a patient unless authorized by the patient or otherwise permitted to do so pursuant to applicable

laws, rules, and/or regulations. This duty has a basis in medical-ethical guidelines and federal and state privacy rights; federal and state laws, rules, and regulations governing both medical records and licensing; and specific federal and state laws, rules, and regulations designed to protect sensitive information (*e.g.,* HIV test results, substance abuse (alcohol/drug) treatment records, and mental health records).

Any Practitioner, APC, or House Staff provider with a question regarding confidentiality and disclosure of medical information may consult with Hospital legal counsel and should refer to applicable Hospital policies including, but not limited to, TriHealth Corporate Policy #08_HIPAA01.00 (HIPAA: Uses and Disclosures of Protected Health Information); TriHealth Corporate Policy #08_HIPAA04.00 (HIPAA: Disclosing PHI to Associates), *etc.*, as such policies may be amended from time to time.

ARTICLE IV
MEDICAL RECORDS

PART A: GENERAL RULES

The attending Practitioner shall be responsible for providing a complete, accurate, and legible medical record for each of his/her patients. A single attending Practitioner shall be identified in the medical record as being responsible for the patient at any given time.

Practitioners, APCs, and House Staff involved in the care of patients shall promptly document the care, treatment, and services provided in each such patient's medical record.

Abbreviations, acronyms, and symbols used should be common across the medical profession and be without contradictory or ambiguous meanings. Abbreviations, acronyms, and symbols are subject to approval by the Health Information Management Committee. For additional information, see TriHealth Corporate Policy 05_MR05.00 (Documenting in the Medical Record), as such policy may be amended from time to time. Where uncertainty exists, the one who wrote the abbreviation, acronym, or symbol must be contacted for clarification.

Documentation in a patient's medical record must accurately and truthfully describe the care, treatment, and/or services provided to the patient and must be recorded upon completion of provision of that care, treatment, and/or service.

PART B: AUTHENTICATION AND COUNTERSIGNATURE

All entries in the medical record shall be dated, timed, and authenticated to verify the entry is complete and accurate by the person responsible for providing or evaluating the care, treatment, and/or services provided. Indication of authentication can include written signature or initials, or computerized/electronic signature recorded by one's own hand. Authentication by computerized/electronic signature is required for any transcribed documents.

Entries made in the medical record by House Staff shall be countersigned by the supervising attending Practitioner in accordance with policies and procedures applicable to the specific residency or fellowship program, as such policies/procedures may be amended from time to time.

All orders, including verbal orders, shall be authenticated in the manner set forth herein.

H&Ps or outpatient assessments (with the exception set forth in Part D/Section 1 of this Article), delegated discharge summaries, and consultation reports prepared by APCs shall be countersigned by the responsible Practitioner.

PART C: CONTENTS

Medical records shall contain sufficient information to: identify the patient; support the diagnosis; justify admission/continued hospitalization and the care, treatment, and services provided; document the patient's progress and response to medications and care, treatment, and services; and facilitate continuity of care.

A complete record shall include, as applicable:

1. Patient identification data
2. Medical history and physical examination (H&P) or outpatient assessment
3. Conclusions or impressions drawn from the H&P or outpatient assessment
4. Problem list
5. Course of action planned
6. Diagnostic and therapeutic orders
7. Evidence of acknowledgment of informed consent
8. Clinical observations, progress notes, and consultation reports
9. Pre-anesthesia assessment and anesthesia plan; post-anesthesia assessment
10. Reports of operative and other invasive procedures
11. Reports of diagnostic and therapeutic procedures such as pathology, clinical laboratory, radiology, and nuclear medicine
12. Final diagnosis(es)
13. Oncology staging
14. Discharge summary or note
15. Discharge instructions
16. Autopsy report
17. Such other information as required by applicable laws, rules, regulations, and/or accreditation standards.

All final diagnoses and complications are recorded without the use of symbols or abbreviations.

PART D: MEDICAL HISTORY AND PHYSICAL EXAMINATION

Section 1. General Requirements

A medical history and physical examination (H&P) shall be completed and documented for each patient no more than 30 days before or within 24 hours after admission or registration of a patient, but prior to surgery or a procedure requiring anesthesia services.

An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the H&P is completed within 30 days before the patient's Hospital admission or registration.

- The update note must document an examination of the patient for any changes in the patient's condition since the patient's H&P was initially performed that might be significant for the planned course of treatment.

- If, upon examination, the Practitioner or APC finds no change in the patient's condition since the H&P was initially completed he/she shall indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was initially completed.

The H&P (and any update thereto) is in effect for the entire length of stay. Any subsequent changes that may occur in the patient's condition must be documented in the progress notes.

The H&P (and any update thereto) shall be completed and documented by a Practitioner or APC who has been granted Privileges by the Hospital to do so; provided that:

- An H&P completed within 30 days before the patient's Hospital's admission or registration may be completed by a Practitioner or APC who is licensed to practice in Ohio, acting within his/her scope of practice, and who may or may not have Privileges at the Hospital so long as an update to such H&P is performed and documented in accordance with the requirements specified above by a Practitioner or APC with Privileges at the Hospital to perform H&Ps.

- H&Ps (and any updates thereto) may be performed and recorded by House Staff as permitted by and consistent with the scope of their current responsibilities within their residency/fellowship training program and applicable laws, rules, and regulations.

The H&P (and any updates thereto) must be signed, dated, and timed by the Practitioner, APC, or House Staff resident/fellow that performed and documented the H&P.

- H&Ps (and any updates thereto) performed and recorded by APCs shall be reviewed and countersigned by the attending Practitioner with the exception that a pre-operative/pre-procedure H&P (or outpatient assessment) performed and recorded by an APC does not require countersignature.

- H&Ps (and any updates thereto) performed and recorded by House Staff must be reviewed, include any addendums if necessary, and countersigned by the supervising attending Practitioner within twenty-four hours after the patient's admission or registration, but prior to surgery or a procedure requiring anesthesia services (except in emergency surgical situations).

Section 2. H&P Content

A full H&P shall document all of the following:

a. The chief complaint, present illness, or condition
b. Medical, family, and social histories
c. A complete body systems review
d. Physical examination
e. Diagnosis(es) or working diagnosis(es)
f. Plan for care

Section 3. H&P for Non-Inpatient Services

Any non-inpatient services that are high risk and/or involve local anesthesia or moderate sedation require the documentation of an H&P. These services include, but are not limited to, cardiac catheterization, endoscopy, and radiology special procedures. Questions regarding the need for an H&P for a non-inpatient service are referred to the Health Information Management Committee.

Section 4. Dental and Podiatric Patients

Additional requirements with respect to completion of H&Ps for dental and podiatric patients is set forth in the Medical Staff Credentials Policy, as such policy may be amended from time to time.

PART E: PROGRESS NOTES

Pertinent progress notes, sufficient to permit continuity of care and transferability, shall be recorded at the time of observation whenever practicable. Each clinical problem should be clearly identified in the notes and correlated with specific orders, results of tests, and care, treatment, and/or services provided. Notes should include reassessment as necessary, the patient's response to the plan of care, changes to that plan, and justification for continued inpatient stay.

Progress notes prepared by the attending Practitioner, a covering Practitioner, or APC, based on an in-person evaluation, are required at least daily except for:

1. The day of discharge, when there is no change in clinical condition; and
2. Patients awaiting nursing home placement.

If a progress note is not written on the date of service, it may be entered at a later date by noting the actual date of documentation and referring to the date and time of service.

Progress notes entered by House Staff shall include any addendums, if necessary, written by the supervising attending Practitioner and be countersigned by the supervising attending Practitioner.

PART F: SURGICAL RECORDS

Surgical records shall include documentation in accordance with Article IX, Part C: Medical Record.

PART G: DISCHARGE SUMMARY OR NOTE

A discharge summary shall be completed for patients with hospital stays of 48 hours or more and shall contain the:

- Reason for hospitalization
- Principal diagnosis and other relevant diagnoses
- Significant findings, procedures performed, and care, treatment, and services rendered
- Patient's condition and disposition at discharge
- Instructions/information provided to the patient and family
- Provisions for follow-up care

The patient's condition at discharge should be stated in terms that permit a specific measurable comparison with the condition upon admission.

For patients with stays under 48 hours, a final progress note may be substituted for the discharge summary. Such note shall document the outcome of hospitalization, disposition of the case (*i.e.,* the patient's condition at discharge), discharge instructions, and provisions for follow-up care.

The discharge summary or final progress note shall be completed within 48 hours after patient discharge.

The attending Practitioner is responsible for preparing the discharge summary or final progress note. A covering Practitioner or APC or House Staff resident/fellow (consistent with the scope of their current responsibilities within their residency/fellowship training program and subject to applicable laws, rules, and regulations) who is knowledgeable about the patient's condition, care during hospitalization, and discharge plans may write the discharge summary or final progress note at the attending Practitioner's request.

The discharge summary (or final progress note) must be authenticated, dated, and timed by the Practitioner, APC, or House Staff resident/fellow who wrote the summary or note. For delegated discharge summaries (or final progress note), the Practitioner (or supervising attending Practitioner with respect to House Staff) responsible for the patient during his/her Hospital stay shall co-authenticate and date/time the discharge summary (or note) to verify its content.

PART H: POSSESSION, ACCESS, AND RELEASE

Release and access to patient health information is governed by TriHealth Corporate Policy #08_HIPAA01.00 (Uses and Disclosures of Protected Health Information), as such policy may be amended from time to time.

ARTICLE V
MEDICAL ORDERS

PART A: GENERAL REQUIREMENTS

Practitioners and APCs shall have the authority to issue orders within their scope of practice and in accordance with their delineated Clinical Privileges and applicable laws, rules, and regulations. All orders must be entered in the patient's medical record and dated, timed, and authenticated promptly by the ordering Practitioner or APC, or by a covering Practitioner who is responsible for the care of the patient.

Practitioners and APCs will enter their own orders while on-site in a TriHealth hospital facility or office with access to TriHealth Connect except when self-entry of orders is impractical. Verbal orders shall be accepted in accordance with the provisions of Article V, Part B, below. Text messaging or texting of orders is not acceptable.

House Staff may write orders as permitted by and subject to applicable laws, rules, regulations, and consistent with the scope of their current responsibilities within their residency/fellowship training program. Orders issued by House Staff are reviewed and countersigned by the supervising attending Practitioner.

Orders must be written clearly, legibly, and completely. The abbreviations, acronyms, and symbols set forth in TriHealth Corporate Policy 05_MR05.00 (Documenting in the Medical Record), as such policy may be amended from time to time, are prohibited. Orders that are illegible or improperly written will not be carried out until they are clarified and understood.

A Practitioner or APC shall reevaluate current orders before and after surgery and upon admission and discharge from an intensive care unit. As needed, orders shall be discontinued and new orders issued.

PART B: VERBAL ORDERS

Requirements regarding verbal orders are set forth in TriHealth Corporate Policy #02_29.00 (Physician Orders: Verbal, Telephone, Faxed), as such policy may be amended from time to time.

PART C: SPECIAL REQUIREMENTS

Section 1. Restraint and Seclusion Orders

Use of restraints and seclusion is limited to clinically appropriate and adequately justified situations. In order to minimize the use of restraints and seclusion, preventive or alternative strategies should be considered. Restraint and seclusion shall be used solely in accordance with the approved procedures specified in TriHealth Corporate Policy #02 17.00 (Restraint and/or Seclusion), as such policy may be amended from time to time.

Section 2. Diagnostic Testing Orders

All requests for diagnostic testing shall contain a statement of the reason for the test.

Section 3. Therapeutic Diet Orders

Orders for therapeutic diets must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

Section 4. Medication Orders

Medication orders shall be written in accordance with Article VI, Part A: Medication Orders.

Section 5. Outpatient Orders

Requirements with respect to orders for outpatient services are set forth in the TriHealth Corporate Policy #11_09.00 (Outpatient Orders by Practitioners), as such policy may be amended from time to time.

ARTICLE VI
PHARMACY

PART A: MEDICATION ORDERS

Section 1. Formulary

Medication orders shall, whenever possible, be in accordance with the Formulary approved by the Pharmacy & Therapeutics (P&T) Committee. Requests for exceptions shall be reviewed by the pharmacist and are granted solely in accordance with TriHealth Corporate Policy #11_12.00 (TriHealth Corporate Pharmacy and Therapeutics Committee), as such policy may be amended from time to time.

Section 2. Content

Unless otherwise provided by applicable laws, rules, and regulations, medication orders shall include the:

a. Intended recipient (*i.e.,* patient specific)
b. Medication name
c. Dose and dosage form
d. Strength
e. Route of administration
f. Frequency
g. Duration, when appropriate
h. Indication for any antimicrobial medication
i. Instructions on how to administer
j. Signature of the authorized prescriber

Section 3. Abbreviations

Use of abbreviations, acronyms, and symbols in medication orders is discouraged and abbreviations, acronyms, and symbols set forth in TriHealth Corporate Policy 05_MR05.00 (Documenting in the Medical Record), as such policy may be amended from time to time, are prohibited. See, also, TriHealth Pharmacy Policy #PHAR-10 (Documentation and Use of Abbreviations).

Section 4. Range Orders

Range doses may be used when the intent of the Practitioner or APC (with prescriptive authority) is to give the patient the lowest possible effective dose of a medication. Range orders may not be used for administration frequency or interval. Range or PRN orders (*e.g.,* one to two tablets every 4 hours PRN) will be titrated in accordance with TriHealth Pharmacy Policy #PHAR-42 (Range Orders for Medications), as such policy may be amended from time to time, unless the prescribing Practitioner or APC gives other specific parameters to nursing for titrating the dose.

Section 5. Order Set Usage

The use of Medical Staff approved order sets is encouraged to facilitate the provision of safe, quality care by ensuring that orders are clear, accurate, and complete. For therapies deemed to be high risk or problem prone, the usage of associated approved order sets may be mandated to reduce the likelihood of harm to patients. Mandated order sets are recommended by the P&T Committee and approved by the Medical Executive Committee. A list of therapies that require usage of an approved order set is provided in Appendix A.

Section 6. Blanket Orders

Use of blanket orders that are written as "resume preoperative orders," "continue previous medications," or "discharge on current medications" are not acceptable. All medication orders must be separately documented through TriHealth Pharmacy Policy #PHAR-31 (Medication Reconciliation), as such policy may be amended from time to time.

Section 7. Medication Reconciliation

Attending Practitioners shall work together with registered nurses and pharmacists in accordance with TriHealth Pharmacy Policy #PHAR-31 (Medication Reconciliation), as such policy may be amended from time to time, to accurately and completely reconcile medications across the continuum of care for patients admitted to the Hospital as an inpatient as well as outpatients, when appropriate.

PART B: DOCUMENTATION OF ADMINISTRATION

Each dose of every medication administered must be individually recorded on the patient's chart.

PART C: ADVERSE DRUG REACTIONS

Section 1. Definition

An adverse drug reaction is defined as any response to a drug which is noxious and unintended occurring at doses used for prophylaxis, diagnosis, therapy of disease, or for modification of physiological function.

Section 2. Response

All adverse drug reactions shall be noted in the progress notes and reported to the attending Practitioner and the Practitioner or APC (with prescriptive authority) who ordered the drug, if different from the attending Practitioner. The Practitioner or APC shall respond as necessary and document that response in the patient's chart in order to notify those treating the patient throughout the duration of the patient's hospitalization. New drug allergy or new adverse drug reaction information shall be entered into the "drug allergy/intolerance" field in the patient's medical record.

Section 3. Reporting

The ordering Practitioner or APC (with prescriptive authority) shall file a safety event report or direct that a safety event report be filed in the Incident Reporting Information System (IRIS) for:

a. Potentially serious, life threatening, or fatal reactions; and
b. New or unexpected severe drug reactions not listed in the drug's labeling.

A safety event report may also be filed for:

a. Untoward effect(s) that are known effects of the drug(s);
b. Untoward drug effect(s) that resulted in a complication, Hospital admission, or prolonged Hospital stay;
c. Untoward drug effect(s) that occur in therapeutic range of monitored drug concentration;
d. Allergic drug reactions; and
e. Any time a reversal agent is used (*e.g.*, Narcan).

Medication errors, near misses, and unexpected adverse drug reactions are reported by Pharmacy to the TriHealth Medication Safety Team and TriHealth P&T Committee.

For the purpose of monitoring adverse drug reactions, the patient's attending Practitioner, APC, nurse, or pharmacist shall initiate an adverse drug reaction report any time a drug reaction is known or suspected. This report shall not become a part of the patient's medical record, but shall be sent to the Pharmacy Department for review by the pharmacist.

For additional information see TriHealth Pharmacy Policy #PHAR-43 (Adverse Drug Reaction & Medication Error Reporting), as such policy may be amended from time to time.

PART D: AUTOMATIC DISCONTINUATION

All orders for oral and parenteral dosage forms for Formulary approved drugs in the category of controlled substances (Schedule II, III, and IV) shall automatically be discontinued in the electronic medical record after the thirtieth (30^{th}) day dosage for that order.

Orders for oral and parenteral dosage forms for non-controlled Formulary approved drugs and biologicals shall automatically be discontinued in the electronic medical record after 365 days.

Monitoring, advance notification of any automatic discontinuation, and enforcement of automatic discontinuation shall be conducted by the Pharmacy as appropriate.

PART E: MEDICATIONS BROUGHT TO HOSPITAL BY PATIENT

Section 1. General Requirements

Medications brought to the Hospital by a patient should be sent home with the patient's representative except as noted in Section 2 below. If sending the medications home is not possible, the drug must be packaged and sealed in a "valuables" envelope and sent to the Security Department to be returned to the patient at discharge. Regardless of disposition, a Practitioner or APC (with prescriptive authority) shall give instructions for use or nonuse of such medications.

Section 2. Limited Exceptions for Use

The use of a medication(s) brought from home by a patient may be permitted provided:

a. The medication is in an appropriately labeled container or has been identified by a Practitioner or APC (with prescriptive authority) or pharmacist; and
b. Is specifically ordered by the attending Practitioner or APC (with prescriptive authority) in the following situations as mutually determined by the Practitioner or APC (with prescriptive authority) and pharmacist:
   (1) Use as an interim dose(s) until a supply is obtained by the Pharmacy; or
   (2) Use in those situations when the drug is non-Formulary; cannot be obtained by the Pharmacy; or must be ordered in an unusually large quantity.

For additional information concerning use of a medication brought from home by a patient, see TriHealth Corporate Policy #02_60.00 (Administration of Own Medications (Brown Bag Medications) Brought by the Patient), as such policy may be amended from time to time.

ARTICLE VII
CONSULTATIONS

PART A: GENERAL RULES

The attending Practitioner is responsible for requesting consultation as indicated below in Parts B and C. When requesting consultation, it is preferred that the attending Practitioner contact the consultant directly to discuss the case.

Any qualified Practitioner with appropriate Privileges may be called as a consultant.

A Department or Section Chair or the Medical Staff President may request a consultation after appropriate discussion with the attending Practitioner. Any of the aforementioned individuals may call in a consultant without discussion with the attending Practitioner in circumstances of grave urgency where consultation is required below in Part B. The System CMO or applicable Regional CMO and the President of the Medical Staff, acting together, shall at all times have the right to call in a consultant(s) if they believe the failure to take such action may result in imminent danger to the health or safety of the patient.

PART B: REQUIRED CONSULTATIONS

A consultation shall be required whenever:

a. Diagnosis and/or management remain in doubt, especially in the presence of life-threatening illness.
b. Significant question arises concerning the appropriateness of a specific test, procedure, or service to meet the patient's need(s).
c. Significant question arises concerning the efficacy of the procedure or treatment in relation to the patient's condition.
d. The attending Practitioner is a Dentist or Podiatrist and the patient requires medical care beyond the scope of such Practitioner's license and Privileges.
e. Unexpected complications arise or specialized treatment or procedures are contemplated which are beyond the scope of the attending Practitioner's delineated Clinical Privileges.
f. Any treatment or procedure might compromise a living pregnancy of less than term gestation.

Furthermore, automatic consultation is provided for intensive care patients in accordance with Article VIII: Intensive Care, Part B: Automatic Intensivist Consultation.

PART C: REQUESTS FOR/COMPLETION OF CONSULTATIONS

Requests for consultation must specify the name of the consulting Practitioner and the nature of/reason for the consultation. Where acuity or complexity warrant completion of a consultation within 24 hours or less, the requesting Practitioner shall also contact and discuss the request with the consulting Practitioner directly.

Consultations should be performed and documented as expeditiously as circumstances require after notification of the request.

PART D: CONSULTATION REPORTS

A consultation shall include examination of the patient and review of the patient's medical record. The consulting Practitioner shall make a record of his/her findings and shall authenticate, date, and time the consultation report.

PART E: CONSULTATIONS BY APPS

An APC may request a consultation from his/her collaborating or supervising Practitioner or from another qualified Practitioner with appropriate Privileges as needed. An APC may provide a consultation, upon request, within his/her scope of practice and consistent with the Privileges granted to such APC at the Hospital in accordance with the requirements, as applicable, set forth in this Article. Consultation reports prepared by APCs must be countersigned by the responsible Practitioner.

PART F: ROLE OF HOUSE STAFF IN CONSULTATIONS

House Staff may participate in requesting, performing, and documenting consultations as permitted by and subject to applicable laws, rules, and regulations and consistent with the scope of their current responsibilities within their residency/fellowship training program.

Documentation of consultation services performed by House Staff shall be reviewed and countersigned by the supervising attending Practitioner and authenticated with a separate Practitioner note as necessary.

ARTICLE VIII
INTENSIVE CARE

PART A: ADMISSION AND DISCHARGE RULES

Patients shall be admitted to and discharged from intensive care units by the attending Physician in accordance with the respective unit's or Medical Staff Department of Critical Care policies for admission and discharge, as such policies may be amended from time to time. Admissions will be prioritized according to the acuity of the patient and the resources available. Discharges shall be expedited as soon as the patient meets the criteria set forth in the respective unit's or Medical Staff Department of Critical Care's discharge policy as such policy may be amended from time to time.

PART B: AUTOMATIC INTENSIVIST CONSULTATION

Section 1. General Requirement

Patients admitted to an adult intensive care unit shall automatically receive consultation from an intensivist. Consultation will be provided by a Physician with appropriate Clinical Privileges in the Department of Critical Care assigned to provide intensivist coverage.

Section 2. Intensivist Responsibilities

While a patient remains in the intensive care unit, the Physician designated as the covering intensivist shall be responsible for:

a. Coordinating all aspects of patient care including appropriate use of further consultations, diagnostics, and treatment;
b. Communicating with other Practitioners, APCs, patients and their authorized representative(s), nursing, and ancillary staff; and
c. Directing daily interaction with the covering House Staff residents/fellows, if applicable.

Section 3. Process

a. The chair of the Department of Critical Care shall publish and distribute a list of privileged intensivists and an intensivist on-call schedule as necessary.

b. Each patient assigned a level of "ICU status" will be seen daily by a member of the Critical Care Medicine team.

ARTICLE IX
SURGERY

PART A: SCHEDULING

Scheduling of surgical cases will be done in accordance with TriHealth Perioperative Services Policy #PO.03 (Block Scheduling), as such policy may be amended from time to time.

PART B: START TIME

Section 1. General Rules

The surgeon shall be in the Hospital and available at the posted case start time. All surgical cases shall begin at the scheduled time to avoid delay of successive cases and the necessity of case postponement. When it becomes evident that a case will not start at the scheduled time, every attempt shall be made to notify the surgeon at least thirty minutes in advance of the scheduled start time. Likewise, the surgeon shall call the main operating room suite control desk when it becomes evident that he or she will be late.

Section 2. Tardiness

Cases starting late due to surgeon tardiness will be reviewed for trends. The Director of Perioperative Services will discuss identified trends with each tardy surgeon. When a surgeon is late fifteen minutes or more for 7:30 a.m. cases greater than three times during a one-month calendar period, the appropriate Department or Section Chair shall be notified for intervention.

Section 3. Postponements Due to Tardiness

Case postponement may occur when the surgeon is late fifteen minutes or more and it becomes obvious that the case cannot be completed on time and delay of successive cases would be inevitable. Case postponement may occur even if a surgeon calls to give notification that he/she will be late. The act of calling shall not ensure the time and availability of an operating room when the surgeon arrives.

PART C: MEDICAL RECORD

Section 1. Pre-procedure Documentation

Except in emergencies, the following data shall be recorded in the medical record prior to surgery or the operation shall be automatically postponed. The patient's medical record shall include:

a. appropriate H&P (or outpatient assessment) including the indication(s) for the procedure and the clinical information necessary for evaluation of the capacity of the patient to withstand anesthesia and surgery;
b. indicated laboratory, EKG, and x-ray findings;
c. pre-sedation or pre-anesthesia evaluation provided on an approved form;
d. provisional diagnosis and plan for the procedure recorded by the surgeon;
e. sedation or anesthesia plan;
f. verification of patient identity and operative site; and

g. informed consent to surgery signed by the patient or the patient's authorized representative.

In an emergency, patient care will take precedence and the medical record will be completed as soon as practicable.

Section 2. Anesthesia Documentation

Two pre-anesthesia assessments must be documented. The first assessment (*i.e.,* pre-anesthesia evaluation) shall be completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services and will include any anesthetic history, cardio-respiratory status, and other parameters required by the applicable Medicare hospital anesthesia services condition of participation to determine that the patient is an appropriate candidate for the planned sedation or anesthesia. The second assessment is performed immediately prior to sedation administration or anesthesia induction to confirm the patient's status and to develop the baseline against which the patient's status is measured throughout the perioperative period.

An intra-operative anesthesia record shall be maintained. This record shall include monitoring values, the dosage and duration of all anesthetic agents, other drugs used, fluids administered (including blood and blood products), any untoward events, and such other information as required by the applicable Medicare hospital anesthesia services condition of participation.

A post-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with Hospital policies and procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care. The post-anesthesia evaluation shall, at minimum, contain the information required by the applicable Medicare hospital anesthesia services condition of participation.

Section 3. Post-procedure Documentation

An operative or other high-risk procedure report shall be entered in the medical record or dictated by the Practitioner who performed the procedure (or a designated House Staff resident/fellow, as permitted by and subject to applicable laws, rules, and regulations, provided that such activity is within the scope of his/her current responsibilities within the residency/fellowship training program) upon completion of the surgery or procedure. Such report shall include the following information:

a. Name and hospital identification number of the patient
b. Date and time of the surgery/procedure
c. Pre-operative diagnosis
d. Name(s) of the primary Practitioner(s) who performed the procedures (including House Staff) and assistants/others who performed surgical tasks (even when performing those tasks under supervision).
e. Description of specific significant surgical tasks that were conducted by House Staff or individuals other than the primary Practitioner who performed the procedure (even when performing those tasks under supervision). Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues.

f. Name of the procedure performed
g. Description of the procedure and techniques used
h. Type of anesthesia administered
i. Description of the procedure findings
j. Complications, if any
k. Description of any tissues or specimen(s) removed or altered
l. Any estimated blood loss
m. Post-operative diagnosis
n. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any

When the full operative/procedure report cannot be entered immediately into the patient's medical record after an operation or other high-risk procedure, the Practitioner who performed the procedure (or designated House Staff resident/fellow as permitted by and subject to applicable laws, rules, and regulations and consistent with the scope of his/her current responsibilities within the residency/fellowship training program) must enter a post-operative or post-procedure progress note in the medical record before the patient is transferred to the next level of care. This progress note must include the name(s) of the primary Practitioner(s), House Staff, and assistant(s), the procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and the postoperative diagnosis.

The full operative or high-risk procedure report and any interim operative or procedure note shall be signed by the Practitioner (or designated House Staff resident/fellow) authoring the report or interim note. An operative/procedure report or interim note prepared by House Staff shall be reviewed and countersigned by the responsible supervising attending Practitioner in accordance with applicable laws, rules, regulations and policies and procedures applicable to the specific residency/fellowship program, as such policies/procedures may be amended from time to time.

Post-operative/post-procedure orders must be provided by the Practitioner who performed the procedure (or designated House Staff resident/fellow consistent with the scope of their current responsibilities within their residency/fellowship training program and subject to applicable laws, rules, and regulations) before the patient leaves the operating or procedure suite or immediately upon arrival in the Post Anesthesia Care Unit.

PART D: OPERATING ROOM CONDUCT

Everyone entering the operating room shall observe all policies and procedures relating to operative suites and perioperative areas (*e.g.,* infection control policies, *etc.*).

PART E: SPECIMENS

Specimens removed during a surgical procedure shall be properly labeled by the Operating Room staff and sent to the laboratory for examination by the pathologist. The pathologist shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information including its source and the pre-operative and post-operative surgical diagnosis, if known.

PART F: POST ANESTHESIA CARE UNIT

The Perioperative Medicine and Anesthesiology Department Chair, or designee, shall act as the Medical Director of the Post Anesthesia Care Unit.

Release of a patient from the Post Anesthesia Care Unit shall be based upon criteria approved by the Perioperative Medicine and Anesthesiology Department.

PART G: DENTAL PATIENTS

Requirements with respect to care of dental patients by Dentists or Oral Surgeons are set forth in the Medical Staff Credentials Policy, as such policy may be amended from time to time.

PART H: PODIATRIC PATIENTS

Requirements with respect to care of podiatric patients by Podiatrists are set forth in the Medical Staff Credentials Policy, as such policy may be amended from time to time.

PART I: ANESTHESIA SERVICES PRIVILEGES

The criteria for determining the anesthesia services Privileges to be granted to a Practitioner or APC and the procedure for applying the criteria to Practitioners or APCs requesting Privileges for any type of anesthesia services shall be generally set forth in the Medical Staff Bylaws and APC Policy and detailed in applicable Hospital/Medical Staff policies (*e.g.,* Credentials Policy, *etc.)* and Privilege sets, as such documents may be amended from time to time.

ARTICLE X
SEDATION & HIGH RISK PROCEDURES

Sedation is administered in accordance with TriHealth Corporate Policy #02_27.00 Sedation Policy: Moderate and Deep), as such policy may be amended from time to time. Pre-procedure and pre-sedation documentation in accordance with TriHealth Corporate Policy #02_27.00 is required for patients receiving moderate (procedural sedation) or deeper sedation.

Post-procedure documentation in accordance with Article IX (Part C/Section 3) is required for high-risk procedures. High-risk procedures include cardiac catheterization, endoscopy, and radiology special procedures requiring sedation or deemed to be high-risk by The Society of Interventional Radiology. Questions regarding documentation requirements for other procedures are referred to the Health Information Management Committee.

ARTICLE XI
LABOR & DELIVERY

PART A: ADMISSION

Patients will be admitted to Labor and Delivery via the Obstetrics Triage Unit or the Emergency Department as outlined in the TriHealth policy, "Care of the Patient in Maternity Triage", Policy Number MAT 116, as such policy may be amended from time to time. External cephalic version, induction of labor, cervical ripening, Cesarean deliveries, Obstetric D&C's and other elective procedures will be scheduled subject to the availability of the patient's obstetrician and Hospital facilities. Obstetricians and Certified Nurse-Midwives (CNM) should be familiar with maternal transport guidelines adopted by the Department of Obstetrics and Gynecology.

PART B: REQUIRED LABORATORY PROCEDURES

Standard prenatal labs are required for admission. The results of these tests shall be recorded on the patient's prenatal history and forwarded to Labor and Delivery prior to the patient's admission. If the results of any of these tests cannot be located upon admission they shall be redrawn at that time. The obstetrician or CNM and anesthesia personnel will determine jointly whether any additional admission or subsequent laboratory tests are needed. Specimens removed during a surgical procedure shall be labeled and sent to the laboratory for examination by the pathologist according to current standards. Cord blood will be drawn from all deliveries.

PART C: PRENATAL RECORD

A prenatal record should be available for all admitted patients. An H&P (or update thereto) is also required for admission. See Article IV, Part D (Medical History and Physical Examination).

PART D: DELIVERY (CESAREAN OR VAGINAL)

The obstetrician or CNM providing prenatal care is responsible for the care of the patient and baby before, during, and after delivery and until the patient and baby are transferred to the care of another Practitioner or Advanced Practice Clinician, as applicable. The obstetrician or CNM is required to be present for the delivery of a patient for whom he or she is responsible and to remain in the delivery area until the patient is stable. Post–delivery orders are required before the patient leaves recovery.

PART E: CERTIFIED NURSE MIDWIVES AND COLLABORATING PHYSICIANS

CNMs granted Privileges to practice at the Hospital shall practice in accordance with their Hospital delineated Clinical Privileges and a current, valid standard care arrangement entered into with the Physician(s) with whom the CNM collaborates. A CNM and his/her collaborating Physician(s) will also sign and comply with the TriHealth Addendum to the Individual Certified Nurse-Midwife Standard Care Arrangement Directing Inpatient Practice Occurring in a TriHealth Hospital.

PART F: ABORTION

TriHealth is committed to the dignity of human life from its beginning. Any

medical procedure directly intending the termination of pregnancy before viability or directly intending the destruction of a viable fetus (that is, abortion) is never permitted.

All providers will adhere to TriHealth Corporate Policy 02_24.01 (Early Delivery and Care of Pregnant Patients During Medical Emergencies) and Guidelines for Early Delivery and Care of Pregnant Patients During Medical Emergencies (Supplement to Corporate Policy 02_24.01), as such policy and guidelines may be amended from time to time.

ARTICLE XII
OUT-OF-HOSPITAL SERVICES

Out-of-Hospital services may be provided to inpatients requiring essential services that are performed regularly by another contracted source(s) approved by the Patient Care Committee. These services are provided in accordance with written agreements defining the nature and scope of the care provided. The Hospital and its Medical Staff require that the sources of such services provide timely care that meets applicable laws, rules, regulations, and accreditation standards.

Otherwise, out-of-Hospital services may be provided to inpatients only in unusual circumstances where a service usually provided at the Hospital is unavailable or the patient has special unmet needs. The attending Practitioner must document the necessity of a patient's movement from the Hospital. Services should be provided by a source accredited by The Joint Commission if practicable. Exceptions require approval of the Department, Section, or Patient Care Committee chair.

The attending Practitioner shall document in the medical record what services were performed and the results thereof.

ARTICLE XIII
DISCHARGE

PART A: GENERAL RULES

Patients shall be discharged pursuant to an order from the attending Practitioner who shall also provide orders for necessary follow-up care and provide any needed instructions to the patient and/or the family.

To the extent permitted by and subject to applicable laws, rules, and regulations and consistent with the scope of their current responsibilities within their residency/fellowship training program, House Staff may facilitate the discharge process in consultation with the supervising attending Practitioner; provided, the supervising attending Practitioner approves and accepts responsibility for the discharge decision by authenticating/countersigning the discharge order.

PART B: DISCHARGE PLANNING

The attending Practitioner shall appropriately participate in discharge planning activities which identify the patient's continuing physical, emotional, symptom management, housekeeping, transportation, social, and other needs, and arrange for services to meet such needs. This process should begin as soon as possible. If Hospital personnel determine discharge planning is necessary in a particular case, that shall be noted in the medical record of the patient.

PART C: DISCHARGE SUMMARY OR NOTE

The attending Practitioner is responsible for completing a discharge summary or note in accordance with Article IV – Part G: Discharge Summary or Note.

PART D: TRANSFER

In all cases of patient movement directly to another medical care facility from the Hospital, consent of the receiving medical care facility must be obtained and documented in the patient's medical record before transfer. Such movement of patients is made in accord with TriHealth Corporate Policies #03_05.00 (Emergency Medical Treatment and Active Labor Act (EMTALA) Screening) and #03_06.00 (Admission/Transfer/Discharge of Patients), as such policies may be amended from time to time.

PART E: DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of his/her parent(s), a legal guardian, a person standing in loco parentis, or another responsible party unless otherwise directed by the parent, legal guardian, or court order. If the parent or legal guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the medical record of the patient.

ARTICLE XIV
DEATHS

PART A: GENERAL REQUIREMENTS

A Physician is responsible for pronouncement of death in accordance with applicable laws, rules, regulations (including, but not limited to, Ohio Administrative Code 4731-14-01) and TriHealth Corporate Policy #02_22.00 (Death: Disposition and Care of the Body), as such policy may be amended from time to time.

Completion of the death certification shall be in accordance with applicable laws, rules, and regulations including, but not limited to, Ohio Revised Code 3705.16.

PART B: BRAIN DEATH

A Physician Member of the Medical Staff with Privileges shall make a determination of death with consideration of criteria approved by the Patient Care Committee. Such criteria are provided in TriHealth Corporate Policy #11_01.00 (Criteria for Determination of Death), as such policy may be amended from time to time, to be utilized as a guideline. The determination of brain death is not restricted to neurologists alone, nor is a consultation by a neurologist required. A repeat neurological examination is optional and dependent on the patient's clinical circumstances.

Medical record documentation can be facilitated by use of the Brain Death Examination Form provided with the above referenced policy.

PART C: AUTOPSY

For performance of an autopsy, all of the following elements must apply or be accomplished.

Section 1. Consultation by the Ordering Physician with the Pathologist

Prior to requesting an autopsy from the family, the Physician must discuss the case with the pathologist to decide the:

a. Best approach to the postmortem exam;
b. Questions to be answered by the examination; and
c. Potential for exposure of the pathologist to a lethal, infectious disease such as:
   (1) Tuberculosis (especially drug-resistant tuberculosis)
   (2) Acquired immunodeficiency syndrome; and
   (3) Creutzfeldt Jacob Disease

Section 2. Physician Requested Autopsy

A Physician Member of the Medical Staff with Privileges may request an autopsy be done on a deceased patient whom the Physician has cared for at the Hospital. Only deaths occurring during an admission and deaths of patients within 30 days after discharge from a prior Hospital admission while in the active care of a Hospital Medical Staff Member with Privileges are eligible for autopsy. This excludes patients who are delivered to the Emergency Department "dead on arrival" (DOA) and Emergency Department deaths unless the deceased person was in the active care of a

Hospital Medical Staff Member with Privileges and discharged from the Hospital within the past 30 days.

The Physician shall discuss the request with the person who has the right of disposition of the body pursuant to Ohio law and must obtain consent for autopsy. The Autopsy Consent Form must be signed by the individual who is legally responsible for the deceased according to the guidelines listed on the reverse side of the Autopsy Consent Form. The discussion will include the extent of the planned autopsy and should be documented in the decedent's medical record. Focused autopsies limited to specific regions are preferred. (See choices listed on the Autopsy Consent Form). The name of the requesting Physician will be entered on the consent and an order entered in the decedent's medical record for the autopsy.

Section 3. Selection Criteria

Medical Staff Members may attempt to secure consent to meaningful autopsies in all eligible deaths that are not subject to, and are waived from, a forensic medical jurisdiction and meet the criteria as follows:

a. Unanticipated or unexplained deaths during or following any procedures or therapies.
b. Unanticipated or unexplained deaths of patients participating in clinical trials (protocols) approved by the Institutional Review Board.
c. Obstetric deaths.
d. Neonatal and pediatric deaths.
e. Deaths of patients where it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplanted organs.
f. Deaths known or suspected to have resulted from environmental or occupational hazards.

Section 4. Family Requested Autopsy (no Physician order)

All family-requested autopsies (*e.g.,* those with no Physician's orders) will be referred to the Department of Pathology at The Ohio State University (OSU) in Columbus, Ohio.

ARTICLE XV
EMERGENCY MEDICAL TREATMENT

PART A: MEDICAL SCREENING EXAMINATION RESPONSIBILITIES GENERALLY

The Hospital shall comply with the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Any individual who comes to the Hospital Emergency Department requesting examination or treatment shall be provided with an appropriate medical screening examination ("MSE") as required under EMTALA and as further described in TriHealth Corporate Policy #03_05.00 ("Emergency Medical Treatment and Active Labor Act—(EMTALA)), as such policy may be amended from time to time.

Patients will be examined to determine if they have an "emergency medical condition" as defined in the Emergency Medical Treatment and Active Labor Act. If an emergency medical condition is determined to exist, the patient will be provided necessary stabilizing treatment, within the capabilities of the staff and facilities available at the Hospital, and/or an appropriate transfer in accordance with the above referenced policy.

PART B: QUALIFIED MEDICAL PERSONNEL

MSEs shall be conducted by Qualified Medical Personnel (QMP) subject to and in accordance with applicable laws, rules, regulations (or authorized waivers thereof), and TriHealth Corporate Policy #03_05.00. The following individuals are designated as such QMPs:

- Emergency Department Physicians with Privileges at the Hospital.
- Where appropriate, other Physicians on the Hospital's Medical Staff with Privileges.
- Emergency Department Physician Assistants (provided that the MSE is within the PA's scope of practice, consistent with the Clinical Privileges granted, and under the supervision of an Emergency Department Physician with Privileges at the Hospital).
- Emergency Department Certified Nurse Practitioners (provided that the MSE is within the CNP's scope of practice, consistent with the Clinical Privileges granted, and in collaboration with an Emergency Department Physician with Privileges at the Hospital).
- Certified Nurse-Midwives (provided that the MSE is within the CNM's scope of practice, consistent with the Clinical Privileges granted, and in collaboration with an obstetrician/gynecologist with Privileges at the Hospital).
- Labor and Delivery Registered Nurses (provided that the MSE is within the RN's scope of practice and under the supervision of an obstetrician/gynecologist with Privileges at the Hospital).
- NICU and SCN Certified Nurse Practitioners (provided that the MSE is within the CNP's scope of practice, consistent with the Clinical Privileges granted, and in collaboration with a neonatologist with Privileges at the Hospital).
- House Staff (as permitted by, subject to, and consistent with the scope of the resident's or fellow's current responsibilities within the residency or fellowship training program and applicable laws, rules, and regulations) under the supervision of the resident's or fellow's supervising Practitioner with Privileges at the Hospital.

Where appropriate and upon activation of the Hospital's emergency management plan and/or declaration of a state or national emergency:

- Emergency Department registered nurses (if permitted by and subject to applicable laws, rules, and regulations provided that the MSE is within the RN's scope of practice and under the supervision of an Emergency Department Physician with Privileges at the Hospital).
- Other Physician Assistants, Certified Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists with Privileges at the Hospital (if permitted by and subject to applicable laws, rules, and regulations provided that the MSE is within each such Advanced Practice Clinician's (APC) scope of practice, consistent with the Clinical Privileges granted, and under the supervision of or in collaboration with the APC's supervising or collaborating Practitioner with Privileges at the Hospital).

PART C: PRACTITIONER ON-CALL COVERAGE

Section 1. On-call Schedules

Each Department Chair is responsible for development and implementation of an on-call coverage schedule(s), as warranted, based on the frequency of emergency cases requiring care in their Department's specialty(ies) and the number of Medical Staff Members with Privileges in such specialty(ies) who are required to take call.

Each Medical Staff Member appointed to a Medical Staff category having an obligation to participate in the on-call schedule shall provide coverage commensurate with his/her Clinical Privileges as assigned.

Section 2. On-call Practitioner Replacements

The on-call Practitioner is responsible for finding a replacement for the on-call schedule if he/she is unable or unwilling to take the scheduled time. The on-call Practitioner must make certain that the replacement Practitioner is a Medical Staff Member with appropriate admitting and other applicable Clinical Privileges. Changes to the call schedule should be communicated to the Medical Staff Services Department.

Section 3. On-call Responsibilities for Emergency Department Patients

a. An on-call Practitioner who has been called from the rotation list cannot refuse to respond.

b. The on-call Practitioner, or their designate, must respond to a page within 30 minutes.

c. The on-call Practitioner, or their designate, must be physically available to the Emergency Department within an appropriate period of time based upon the needs of the patient.

d. An on-call Practitioner may direct a licensed physician assistant (PA) or advanced practice registered nurse (APRN) (whom the Physician supervises or collaborates with and consistent with the PA's or APRN's respective scope of practice and Clinical Privileges at the Hospital) as the on-call Practitioner's representative to appear at the Hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical needs and the capabilities of the Hospital, the applicable State scope of practice laws, the Medical Staff governing documents, and

applicable Hospital policies and procedures. Notwithstanding the foregoing, the designated on-call Practitioner is ultimately responsible for providing the necessary services to the individual in the Emergency Department/Hospital, regardless of who makes the in-person appearance. Furthermore, in the event that the treating Practitioner disagrees with the on-call Practitioner's decision to send a representative and requests the actual appearance of the on-call Practitioner, then the on-call Practitioner is required under EMTALA to appear in person. Both the Hospital and the on-call Practitioner who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

e. The on-call Practitioner must accept all emergency patients he/she is clinically capable of caring for regardless of the patient's ability to pay.

f. The on-call Practitioner must admit those patients requiring inpatient Hospital care and follow such patients until the acute illness is resolved, he/she transfers care of the patient to another Practitioner, or care is terminated by the patient.

g. Emergency Department patients should have easy access for necessary outpatient follow-up care that is not subject to unreasonable financial or scheduling barriers. Payment cannot be required before their first office visit. The on-call Practitioner must also follow patients referred for outpatient care until the acute illness is resolved, he/she transfers care of the patient to another Practitioner, or care is terminated by the patient.

h. Subject to subsection (i), if there is a disagreement between the on-call Practitioner and the Emergency Department Physician regarding acute or follow-up care, the case may be transferred, as applicable, either to the second on-call Practitioner; the Section Chair or their designee; or the Department Chair or their designee. The Emergency Medicine Department Chair will review these cases with the appropriate Section or Department Chair.

i. The need for on-site evaluation of an Emergency Department patient will be determined jointly by the Emergency Department Physician and the on-call Practitioner. If a satisfactory decision cannot be reached, the responsibility for resolution will rest with the appropriate Section/Department Chair; provided, however, that if the Section/Department Chair is not available, the decision of the Emergency Department Physician will control and the matter can be discussed following the provision of care.

j. The fact that an on-call Practitioner has previously terminated a physician/patient relationship with a patient is not a basis for refusing to see that patient in the Emergency Department as part of a Practitioner's on-call responsibilities. However, the on-call Practitioner may arrange for another Practitioner with appropriate Privileges to cover for the on-call Practitioner provided there is no delay in the care to the patient.

k. The Emergency Medicine Department Chair will forward cases where there is a concern that the on-call Practitioner has acted outside these parameters to the appropriate Section or Department Chair for review and any warranted follow-up

Section 4. On-call Responsibilities for Inpatients

a. The on-call Practitioner is responsible for providing Hospital inpatient consults pertaining to their specialty if: an inpatient does not have a current physician-patient relationship with a Practitioner in that specialty; or, the specialist with whom the patient has a physician-patient relationship lacks the necessary Clinical Privileges; or, a specialist with Privileges at the Hospital and with whom the patient has a physician-patient relationship is unavailable.

b. Hospital inpatient consults should be made in a reasonable time frame no later than the next day or sooner as medically indicated and warranted by the patient's condition.

Section 5. On-Call Schedule Failure

When the first on-call Practitioner for a Section or Department fails to respond, the second on-call Practitioner for that specialty, if any, shall be called. In the absence of a second named on-call Practitioner or their failure to respond, the appropriate Section Chair, if any, shall be contacted. In the absence of a Section Chair or their failure to respond, the appropriate Department Chair shall be contacted. The Section or Department Chair shall arrange for another member of the Section or Department with appropriate Privileges to provide coverage. If all of the above are unavailable, a substitute Practitioner with appropriate Privileges can be contacted if practicable. Otherwise, a patient may be transferred if appropriate coverage cannot be provided in a timely fashion. The President of the Medical Staff shall be notified when coverage is not obtained through either the on-call schedule or follow-up with the Section or Department Chairs.

ARTICLE XVI
MISCELLANEOUS

PART A: SMOKING

Section 1. By Practitioners and APCs

Smoking by Practitioners and APCs at the Hospital is prohibited in accordance with TriHealth Corporate Policy # SE10.00 ("Tobacco Free/Smoke Free Facilities). Practitioner and APC violations shall be reported to the Medical Staff Services Department for appropriate follow-up.

Section 2. By Patients

Patient smoking is prohibited in the Hospital's facilities unless there is a written prescription from a Practitioner or APC. A prescription may only be written for adult inpatients who are terminally ill, dysfunctional, or psychiatric patients. Regardless of a prescription, smoking is never permitted:

a. In a room where therapeutic compressed gases are in use.
b. When a patient is confined to bed without a responsible person (volunteer, family member, employee, *etc.*) in attendance at all times.
c. When, in the judgment of the nurse or a Practitioner/APC, a patient is unable for any reason (*e.g.,* physical, mental, medicated, *etc.*) to be responsible for preventing a fire.

PART B: GRADUATE MEDICAL EDUCATION PROGRAM PARTICIPANTS

Section 1. General Rules

Each participant in a professional graduate medical education (GME) residency or fellowship program will be supervised during their clinical rotation by an attending Practitioner with Clinical Privileges appropriate to the residency or fellowship program in which the participant is a part. Only participants in a TriHealth professional GME residency or fellowship program or a residency/fellowship program affiliated with TriHealth through a signed agreement may participate in the care of patients as part of the participants' clinical education. Appropriate supervision will be coordinated by the respective residency or fellowship program director.

House Staff are given patient care responsibilities (under the supervision of a teaching attending Practitioner) commensurate with the House Staff resident's or fellow's level of training, experience, and capability; as permitted by and consistent with the scope of each such resident's or fellow's current responsibilities within the residency or fellowship training program; subject to applicable laws, rules, and regulations; and, as otherwise detailed in training policies, procedures, protocols, and educational agreements developed by the applicable training program director in accordance with the Accreditation Council for Graduate Medical Education or the Council on Podiatric Medical Education, as applicable.

In all matters of patient care, House Staff are responsible to and under the supervision of a teaching attending Practitioner who maintains ultimate decision-making authority and responsibility for care of the patient. House Staff performance of assigned patient care responsibilities does not

preempt the supervising attending Practitioner's right/responsibility to do any or all of the tasks assigned to House Staff.

Individuals from non-affiliated GME residency or fellowship programs with which TriHealth has no academic agreement generally may only observe and are prohibited from participation in the clinical care of any patient, writing orders, or documenting in the medical record. Deviations from this rule require approval in advance by the Vice President of Academic Affairs.

For additional information see GME Policy #11.04.00 (Visiting Resident Physicians/Fellows) and GME Policy # 5097- 1047 (Observerships), as such policies may be amended from time to time.

Section 2. Supervising Attending Practitioner

Attending Practitioners serving as faculty for professional GME residency or fellowship programs shall provide supervision in accordance with the policies of the respective GME residency or fellowship program including, but not limited to, GME Policy #5097-1007 (Supervision), as such policies may be amended from time to time.

Section 3. Peer Review

The acts of participants in a professional GME program are subject to review through the Medical Staff peer review processes. Program directors are responsible for assuring timely and complete response to all peer review queries.

Section 4. GME Committee Duties

The GME Committee shall communicate with the Patient Care Committee at least annually and more frequently as necessary about the safety and quality of patient care provided by, and the related educational and supervisory needs of, participants in professional GME residency and fellowship programs. Each year, the GME Committee shall provide the Patient Care Committee with written descriptions of the roles, responsibilities, and patient care activities of GME program participants. These descriptions include identification of the mechanisms by which each participant's supervisor(s) and GME program director make decisions about each such participant's progressive involvement and independence in specific patient care activities.

APPENDIX A
MANDATORY ORDER SETS

The use of approved order sets is mandated in accordance with Article VI, Part A, Section 5 for the following therapies:

1. Oncologic Antineoplastic
2. Hyperalimentation
3. Therapeutic anticoagulation orders
   a. Weight-based heparin
   b. Coumadi (Warfarin)
   c. Lovenox (Enoxaparin)
   d. Parenteral Direct Thrombin Inhibitors
4. Brexanolone (Zurlesso) infusion
5. Treprostinil (Remodulin)
6. Any other medications as directed by Pharmacy and Therapeutics Committee decision.