THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute
as of May 18, 2021

01 Ethical pledge.

(A) Each member of the medical staff and health care providers with clinical privileges shall pledge adherence to standard medical ethics, including:

(1) Refraining from fee splitting or other inducements relating to patient referral;

(2) Providing for continuity of patient care;

(3) Refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental practitioner or other licensed healthcare professional who is not qualified to undertake this responsibility or who is not adequately supervised;

(4) Seeking consultation whenever necessary; and

(5) Never substituting physicians without the patient's knowledge or appropriate consent.

(Board approval dates: 7/7/2006, 8/31/2012, 4/6/2016)

02 Admission procedures.

(A) Except in an emergency, in the interest of assignment to the appropriate service, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician a member of the attending staff, limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the responsible medical staff member. The request for admission shall also include the following information:

(1) Any facts essential for the protection of the general hospital population against unnecessary exposure to infectious and other communicable diseases.

(2) Any information which will warn responsible hospital personnel of any tendency of any patient to commit suicide or to injure others because of mental disturbance.

(3) Any information concerning physical condition or personality idiosyncrasy which might be objectionable to other patients who might be occupying the same or adjoining rooms.

(B) It shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of mental or substance disorders and to order such precautionary measures as may be necessary to assure protection of the patient and the protection of others whenever a patient might be a source of danger. The attending physician is responsible to provide a comprehensive plan of care, including emergency care.

(Board approval dates: 9/18/2009, 4/6/2016)

03 Attending assignment.

(A) All patients entering the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI) who have not requested the services of a member of the medical staff to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to the CHRI. This shall also apply to the transfer of patients within the services of the CHRI.

(B) Alternative attending medical staff member coverage.

Each division shall have a plan for medical coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or limited medical staff who have accepted this responsibility and who shall be called to attend his or her patients if the responsible attending medical staff member is not available, the director of medical affairs, section chiefs, department chair or his designee shall have authority to contact any member of the medical staff and arrange for coverage should the attending medical staff member and the alternate be unavailable.

(C) In the case of a medical or psychiatric emergency involving a patient, visitor or CHRI staff member in an inpatient or outpatient setting, any individual who is a member of the medical staff or who has been delineated privileges is permitted to do everything possible to save the life or prevent serious harm regardless of the individual's staff status or clinical privileges.

(Board approval dates: 11/4/2005, 2/11/2011, 4/6/2016)

04 Consultations.

(A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the medical staff member’s area of training and experience, it is the responsibility of the medical staff member or his or her designee (with appropriate credentials) to obtain consultation by the appropriate specialist. The consultation may be ordered by the responsible medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges as designated in these rules and regulations. If a consultation is ordered prior to 10:00 a.m., the consult shall occur on the same business day. If a consultation is ordered after 10:00 a.m., the consult shall occur within twenty-four hours. Each patient is continuously assessed and his or her plan for care if modified as necessary.

(B) Responsibility to monitor consultations.

It is the duty of the medical staff, through its clinical section chief and the medical staff administrative committee, to assure that members of the staff comply in the matter of requesting consultations as needed.

(C) Consultation contents.

A satisfactory consultation shall be rendered within one day of the request and shall include examination of the patient, examination of the medical record, and a written opinion signed by the consultant that is made a part of such record. If operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 4/8/2011, 4/6/2016)

05 Order writing privileges.

(A) Definition of "patient orders".

(1) A patient order(s) is a prescription for care or treatment of patients. An order can be given verbally, electronically or in writing to qualified personnel identified by category in paragraph (C) of this rule and shall be authenticated by the licensed medical practitioner, a member of the limited staff, or another licensed healthcare professional with appropriate clinical privileges. Patient orders may be given initially, renewed, discontinued or cancelled. Throughout these rules and regulations, the word “written” and its grammatical derivatives, as used to describe a nonverbal order, refer to both written and electronically entered orders.

(2) Electronic orders are equivalent and have the same authority as written orders. Electronic orders have been expressly structured to mirror these rules and regulations and all policy guidelines adopted by the medical staff and hospital administration.

(B) Responsible medical practitioner.

All patient care is the responsibility of the attending, associate attending, clinical attending, or community associate attending staff. Coverage may be provided by the limited staff or another licensed healthcare professional with appropriate clinical privileges under supervision. The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) with appropriate clinical privileges responsible for the hospitalization or outpatient care, and treatment of the patient is responsible for all orders for the patient. Attending, associate attending and clinical medical staff may designate members of the limited staff, or other licensed healthcare professionals with appropriate clinical privileges to write or electronically enter orders under their direction. The attending staff member may also designate members of the pre-M.D. medical student group to write or electronically enter orders, but in all cases these orders shall be signed by the physician, dentist, psychologist, podiatrist, or designated limited staff member who has the right to practice medicine, dentistry, psychology, or podiatry and who is responsible for that patient's care prior to the execution of the order. Supervising physicians may delegate to a medical staff member (who is appropriately credentialed) the ability to relay, enter, transcribe or write orders for routine laboratory, radiologic and diagnostic studies under their direction, but, in all cases, the order shall be co-signed by the supervising physician within twenty-four hours of the order being written. Community associate staff coverage may be provided by the limited staff under supervision.

(C) Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited medical staff, or other licensed healthcare professionals with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the director of medical affairs and each chief of the clinical service where they will exercise clinical privileges, and only where said health care provider is exercising responsibilities which have been approved and delineated by job description for employees of the hospital, or by the customary medical staff credentialing process when the provider is not an employee of the hospital. Lists of the approved titles or categories of providers shall be maintained by the director of medical affairs. Verbal orders should be utilized infrequently. The individual giving the verbal or telephone order must verify the complete order by having the person receiving the information record and “read back” the complete order to assure the quality and safety of patient care. The job description or delineated privileges for each provider must indicate each provider’s authority to receive telephone or verbal orders, including but not limited to the authority to receive orders for medications. The order is to be recorded and authenticated by approved health care provider to whom it is given as “verbal order by _____,” or “V.O. or T.O. by _____,” giving the licensed healthcare practitioner’s name and the time of the order, followed by the approved health care provider’s signature and date, and read back in its entirety to the ordering physician, dentist, psychologist, podiatrist, designated limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. All verbal orders for DEA schedule II controlled substances, patient seclusion, or patient restraint must be

authenticated within twenty-four hours by signature of a licensed physician, dentist, podiatrist, psychologist, or designated limited staff member or other licensed healthcare professionals with appropriate clinical privileges. Verbal orders for directives of urgent issues that cannot be addressed by the prescriber's order entry are encouraged to be signed electronically within forty-eight hours, but must be authenticated within twenty-one days by signature by a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(D) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must be developed, approved, used and monitored in strict compliance with the standing orders medical staff policy approved by the medical staff administrative committee and hospital administration.

(E) Preprinted orders.

Preprinted order forms for patients must be reviewed, dated, timed and signed by a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges before becoming effective.

(F) Investigational drug orders.

Evidence of informed patient consent must be available to a nurse or pharmacist before an investigational agent is ordered and administered. Investigational drugs may be ordered only upon authorization of the principal or co-investigator or other delegated physician, dentist, or podiatrist named in FDA forms 1572 or 1573. Registered nurses or pharmacists who are knowledgeable about the investigational agents may administer the drugs to patients.

(G) Change of nursing service.

Level of care is defined as the type and frequency of medical and nursing interventions required to appropriately manage the medical and nursing care requirements of the patient. "Change of level of care" means official and physical movement (transfer) of a patient from an inpatient or observation care unit providing one level of care to another providing a different level of care, with or without change in attending physician, dentist, psychologist or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed or rewritten upon transfer by signature of a responsible medical practitioner. The new or renewed orders may be written or electronically entered before or when the patient arrives on the receiving unit and may become effective immediately.

In each case of "change of nursing service," it is the responsibility of the receiving nurse to establish the availability of renewed or new written or electronically entered orders. Prior orders will remain in effect until new orders are available. This should be done within eight hours of transfer.

(H) "Transfer of clinical service" means transfer of full patient responsibility from one attending physician, dentist, psychologist or podiatrist to another; the patient may remain on the same unit or a change in patient care area may also occur. Admission of a patient from an emergency service to the hospital as an inpatient involves "transfer of clinical service."

For the purposes of order writing or electronically entering orders, two essentials of "transfer of clinical service" are necessary:

(1) The initial transfer order must indicate the release of responsibility and control of the patient, pending acceptance by the receiving service. The order may read "transfer (or admit) to Dr., head and neck service."

(2) Transfer of service may be completed only by the receiving service writing an order to the effect "accept in transfer (or admission) to Dr., head and neck service."

Orders effective before the transfer must be renewed or rewritten upon transfer by signature of a responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges. The new or renewed orders may be written or electronically entered before or at the time of transfer, and may become effective immediately. It is the responsibility of the receiving nurse to establish the availability of new or renewed orders. If new orders are unavailable, then the nurse may continue previous orders and immediately notify the responsible medical practitioner, a limited staff member, or other licensed healthcare professionals with appropriate clinical privileges.

(I) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist or podiatrist for a brief period of time does not constitute or require "transfer of clinical service" unless so desired and agreed upon by the physician, dentist, or podiatrist and patient.

(J) Hospital discharge/readmission orders.

Hospital discharge from standard inpatient units or day care unit to outpatient status requires appropriate discharge orders. Readmission to any inpatient unit requires new, rewritten/reentered or renewed orders by signature of the responsible medical practitioner, limited staff member, or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(K) Do not resuscitate orders.

The order for do not resuscitate indicating that the patient should not undergo cardiopulmonary resuscitation may be written only by the attending physician or his delegate. Verbal orders for do not resuscitate will not be accepted under any circumstances. The order for do not resuscitate may be rescinded only by the attending physician or delegate and an order must be written to annul said order. Please refer to hospital policy 03-24 do not resuscitate orders for further details.

(L) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) order designating the patient as inpatient or outpatient (observation). The appropriate level of care (ALOC) order may be written a signed by the attending physician. If the ALOC order for inpatient admission is written by a member of the limited staff or other licensed healthcare practitioner with appropriate clinical privilege, it must be co-signed by the attending physician prior to the patient being discharged from the hospital. Admission to any inpatient unit or placing a patient in observation status requires new, rewritten/reentered or renewed orders by the responsible medical practitioner or limited staff member or other licensed healthcare professional with appropriate privileges and under the supervision of the responsible medical staff member.

(Board approval dates: 4/6/2016, 9/2/2016)

06 Death procedures.

(A) Every member of the medical staff shall be actively interested in securing necropsies in every death on their service. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

(B) The death of a patient in the hospital within twenty-four hours of admission must be reported to the proper legal authorities under the laws of Ohio.

(C) When a necropsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(D) Criteria for autopsy requests include the following:

(1) Coroner's cases when the coroner elects not to perform an autopsy. The county coroner has jurisdiction for performing an autopsy when death is the result of violence, casualty, or suicide, or occurs suddenly in a suspicious or unusual manner. Deaths occurring during surgery or within twenty-four hours of admission to the hospital are also coroner's cases, and the decision whether to autopsy is the coroner's responsibility. When the coroner elects not to perform an autopsy, a request of an autopsy shall be made pursuant to paragraph (A) of this rule.

(2) Unexpected or unexplained deaths, where apparently due to natural causes or due to those occurring during or following any surgical, medical, or dental diagnostic procedures or therapies.

(3) Undiagnosed infections disease where results may be of value in treating close contacts.

(4) All deaths in which the cause of death is not known with certainty on clinical grounds.

(5) Cases where there is question of disease related to occupational exposure.

(6) Organ donors (to rule out neoplastic or infectious disease).

(7) Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide assurance to them regarding the same.

(8) Deaths in which autopsy may help to explain unknown or unanticipated medical complications to the attending.

(9) Deaths of patients who have participated in investigational therapy protocols.

(10) Deaths in which there is a need to enhance the education and knowledge of the medical staff and house staff. The attending practitioner shall be notified of the autopsies performed by the pathology department.

(E) When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the record within sixty days.

(Board approval dates: 11/4/2005, 4/6/2016)

07 Emergency preparedness.

(A) Emergency care.

Emergency care is considered to be treatment rendered to stabilize the patient prior to transport to the Ohio state university hospital's emergency department or other appropriate facility as the patient's condition dictates.

(B) Disaster preparedness.

In case of a civil, military, natural emergency or disaster, patients may be discharged from the CHRI, moved to other community hospitals, or moved to other facilities made available for the care and treatment of patients, by the order of the director of medical affairs of the CHRI or the director of medical affairs designated agent, to preserve life and health, to make room for more critically ill or injured patients sent to the hospitals from a disaster area or for the purpose of saving lives and to provide adequate medical care and treatment.

(Board approval dates: 11/4/2005, 2/6/2009, 4/6/2016)

08 Surgical case review (tissue committees).

Surgical case review shall be performed on an on-going basis by each department regularly doing surgical procedures in conjunction with the clinical quality management committee. The review shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses. Discrepancies between the clinical impression and tissue removed during a surgical procedure are identified by pathology and then referred to the appropriate department for review. A screening mechanism based on predetermined criteria may be established for cases involving no specimens. Written records of the evaluations and any action taken shall be maintained in the quality and operations improvement department, and be available to the director of medical affairs, the CHRI section chief, department chairperson or their designees.

(Board approval dates: 11/4/2005, 4/6/2016)

09 Tissue disposition.

All tissue and foreign bodies removed during a surgical procedure shall be sent to the pathology laboratory for examination except for the following categories. These exceptions may be invoked by the attending surgeon only when the quality of care is not compromised by the exception when another suitable means of verification of the removal is routinely employed and when there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from pathological examination are the following:

(A) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

(B) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

(C) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

(D) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

(E) Specimens known to rarely if ever show pathological change, and removal of which is highly visible postoperatively.

(F) Teeth, provided the number including fragments is recorded in the medical record.

(G) Specimens for gross only examination.

(H) Medical devices. Soft tissue accompanying medical devices may be submitted for microscopic examination if deemed appropriate by the pathologist.

(I) Foreign bodies that are hard and cannot be decalcified. Accompanying soft tissue may be submitted for microscopic examination if deemed appropriate by the pathologist.

(J) Portions of bone removed from feet for bunions/hammer toes, if microscopic exam deemed unnecessary by pathology.

(K) Portions of rib removed for operative exposure only and not designated "disposal only." At the pathologist's discretion, marrow samples from such ribs may be submitted for microscopic examination.

(L) Nasal bone and cartilage removed for deviated septum (does not apply if deviation due to neoplastic or inflammatory process). If soft tissue accompanies nasal bone and cartilage, it may be examined at pathologist's discretion.

(Board approval dates: 11/4/2005, 4/6/2016)

10 Medical records.

(A) Each member of the medical staff shall conform to the following medical information management department policies:

(1) Medical record contents.

(a) The attending physician is ultimately responsible for the preparation of a complete medical record for each patient. The medical record may contain information collected and maintained by members of the medical staff, limited staff, other licensed healthcare professionals, medical students or providers who participate in the care of the patient. This record shall including the following elements as it applies to the patient encounter:

(i) Identification demographic data including the patient’s race and ethnicity.

(ii) The patient’s language and communication needs.

(iii) Emergency care provided to the patient prior to arrival, if any.

(iv) The legal status of patients receiving mental health services.

(v) Evidence of known advance directives.

(vi) Statement of present complaint.

(vii) History and physical examination.

(viii) Any patient generated information.

(ix) Provisional diagnosis.

(x) Documentation of informed consent when required.

(xi) Any and all orders related to the patient’s care.

(xii) Special reports, as those from:

(a) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.

(b) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

(c) The radiology department.

(d) Consultants as verified by the attending medical staff member's signature.

(xiii) Medical and surgical treatments.

(xiv) Progress notes.

(xv) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.

(xvi) An intra-operative anesthesia record.

(xvii) Postoperative documentation records, the patient's vital signs and level of consciousness; medications, including IV fluids, blood and blood components; any unusual events or postoperative complications; and management of such events.

(xviii) Postoperative documentation of the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

(xix) A post anesthesia follow-up report written within forty-eight hours after surgery by the individual who administers the anesthesia.

(xx) All reassessments and any revisions of the treatment plan.

(xxi) Every dose of medication administered and any adverse drug reaction.

(xxii) Every medication dispensed to an inpatient at discharge.

(xxiii) Summary and final diagnosis as verified by the attending physician's signature.

(xxiv) Discharge disposition, condition of patient at discharge, instructions given at that time and the plan for follow up care.

(xxv) Any referrals and communications made to external or internal providers and to community agencies.

(xxvi) Any records of communication with the patient made by telephone or email or patient electronic portal.

(xxvii) Memorandum copy of the death certificate when applicable.

(2) Deadlines and sanctions.

(a) A procedure note shall be entered in the record by the responsible attending medical staff member or the medical staff member's designee (who is appropriately credentialed) immediately upon completion of an invasive procedure. Procedure notes must be written for any surgical or medical procedures, irrespective of their repetitive nature, which involve material risk to the patient. Notes for procedures performed in the operating rooms must be finalized in the operating room information system by the attending surgeon. For any formal operative procedures, a note shall include pre-operative and post-operative diagnoses, procedure(s) performed and description of each procedure, surgeon(s), resident(s), anesthesiologist(s), surgical service, type of anesthesia (general or local), complications, estimated blood loss, any pertinent information not included on the O.R./anesthesia record, preliminary surgical findings, and specimens removed and disposition of each specimen. Where a formal operative procedure report is appropriate, the report must be completed immediately following the procedure. The operative/procedure report must be signed by the attending medical staff member. Any operative/procedure report not completed or any procedure note for procedures completed in the operating rooms not completed in the operating room information system by 10:00 a.m. the day following the procedure shall be deemed delinquent and the attending medical staff member responsible shall lose operating/procedure room and medical staff privileges the following day. The operating rooms and procedure rooms will not cancel cases scheduled before the suspension occurred. Effective with the suspension, the attending medical staff member will lose all privileges to schedule elective cases. Affected medical staff members shall receive telephone calls from the medical information management department indicating the delinquent operative/procedure reports.

(b) Progress notes must provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition or results of treatment. A progress note must be completed by the attending medical staff member or his or her designated member of the limited medical staff or practitioner with appropriate privileges at least once every day. Each medical student or other licensed health care professional progress note in the medical records should be signed or counter-signed by a member of the attending, courtesy, or limited staff.

(c) Medical staff members with more than twenty-five verbal orders that remain unsigned greater than twenty-one days after the date of the order will be subject to corrective action including administrative suspension which may include suspension of admitting and operating room scheduling privileges until the orders are signed. Medical staff members shall be notified electronically prior to suspension for unsigned verbal orders.

(d) Birth certificates must be signed by the medical staff member who delivers the baby within one week of completion of the certificate. Fetal death certificates and death certificates must be signed and the cause of death must be recorded by the medical staff member with a permanent Ohio license within twenty-four hours of death.

(e) Outpatient visit notes and letters to referring physicians, when appropriate, shall be completed within three days of the patient’s visit.

(f) All entries not previously defined must be signed within ten business days of completion.

(g) Queries by clinical documentation specialists requesting clarification of a patient's diagnoses and procedures will be resolved within five business days of confirmed notification of request.

(h) Office visit encounters shall be closed within one week of the patient's visit.

(3) Discharges.

(a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, a limited staff member or other licensed healthcare professional.

(b) At the time of discharge, the appropriately credentialed attending medical staff member, limited staff member, or other licensed healthcare professional is responsible for certifying the principal diagnosis, secondary diagnosis, the principal procedure, if any, and any other significant invasive procedures that were performed during the hospitalization. If a principal diagnosis has not yet been determined, then a "provisional" principal diagnosis should be used instead.

(c) The discharge summary must be available to any facility receiving the patient before the patient arrives at the facility. Similarly, the discharge summary must be available to the care provider before the patient arrives at any outpatient care visit subsequent to discharge. The discharge summary should be available within forty-eight hours of discharge for all patients. The discharge summary should be signed by the responsible attending medical staff member within forty-eight hours of availability.

(d) The discharge summaries must contain the following elements:

i. hospital course including reason for hospitalization and significant findings upon admission;

ii. principal and secondary diagnoses or provisional diagnosis;

iii. relevant diagnostic test results;

iv. procedures performed and care, treatment and services provided;

v. condition on discharge;

vi. medication list and medication instructions;

vii. plan for follow-up of tests and studies for which results are pending at discharge;

viii. coordination and planning for follow-up testing and physician appointments;

ix. plans for follow-up care and communication, and the instructions provided to the patient.

(e) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional who is appropriately credentialed by the hospital, within twenty-one days of discharge of the patient.

(f) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medial staff members shall have their admitting and operative scheduling privileges suspended until all records are completed. Attending medical staff members shall receive electronic notification of delinquent records. If an attempt is made by the attending medical staff member, or the attending medical staff member's designee, who is appropriately credentialed by the hospital, when applicable, to complete the record, and the record is not available electronically for completion, the record shall not be counted against the attending medical staff member. Medical staff members who are suspended for a period of longer than one hundred twenty consecutive days are required to appear before the practitioner evaluation committee.

(g) Records which are incomplete greater than twenty-one days after discharge or the patient's visit are defined as delinquent.

(4) Confidentiality.

Access to medical records is limited to use in the treatment of patients, research, and teaching. All medical staff members are required to maintain the confidentiality of medical records. Improper use or disclosure of patient information is subject to disciplinary action.

(5) Ownership.

Medical records of hospital sponsored care are the property of the hospital and shall not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) Informed consent documentation.

(a) Where informed consent is required for a special procedure (such as surgical operation), documentation that such consent has been obtained must be made in the hospital record prior to the initiation of the procedure.

(b) In the case of limb amputation, a limb disposition form, in duplicate, must be signed prior to the operation.

(8) Sterilization consent.

Prior to the performance of an operative procedure for the expressed purpose of sterilization of a (male or female) patient, the attending medical staff member shall be responsible for the completion of the legal forms provided by the hospital and signed by the patient. Patients who are enrolled in the Medicaid program must have their forms signed at least thirty days prior to the procedure. Informed consent must also be obtained from one of the parents or the guardian of an unmarried minor.

(9) Criteria changes.

The medical information management department shall make recommendations for changes in the criteria for record completion with approval of the medical staff.

(10) Entries and authentication.

(a) Entries in the medical record can only be made by staff recommended by the medical information management department subject to the approval of the medical staff.

(b) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person, identified by name and credentials, who is responsible for ordering, providing, or evaluating the service furnished.

(c) The electronic signature of medical record documents requires a signing password. At the time the password is issued, the individual is required to sign a statement that she/he will be the only person using the password. This statement will be maintained in the department responsible for the electronic signature.

(d) Signature stamps may not be used in the medical record.

(11) Abbreviations.

Abbreviations, acronyms and symbols appearing on the non-approved abbreviations list may not be used in the medical record.

(Board approval dates: 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019)

11 Committees.

In addition to the medical staff committees, the medical staff shall participate in the following hospital and monitoring functions: infection control, clinical quality management, safety, and disaster planning and in other quality leadership council policy groups.

Operating Room Committee

(A) The operating room committee shall have representation from all clinical departments utilizing the operating room. Representation will include: medical director of the CHRI operating room, the section or division chief, or their designee, of: surgery, gynecologic oncology, urology, otolaryngology, radiation oncology, thoracic surgery, surgical oncology, neurological surgery, orthopedic surgery, anesthesia, and plastic surgery; epidemiology/infection control, the medical director of perioperative services for the Ohio state university, the CHRI medical director of quality, the director of perioperative services of the CHRI operating room, the manager of perioperative services, the director of admitting, the operating room coordinator, and the CHRI director of operations. The committee chair will be a

CHRI surgeon selected by the nominating committee and shall serve a two-year term beginning on the first of July. The committee shall meet monthly and carry out the following duties:

(1) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned, including allocation of operating room resources. Allocation of operating room time will be done by the director of medical affairs and approved by the operating room committee.

(2) Monitor quality concerns and consider problems and improvements in operating room functions brought to its attention by any of its members.

(3) Monitor medical staff compliance with operating room policies established for patient safety, infection control, access and throughput, and smooth functioning of the operating rooms.

(4) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president of health services, the director of medical affairs, and the executive director of the CHRI.

(B) Each member of the medical staff shall conform to the policies established by the operating room committee, including the following:

A member of the surgical attending staff and a member of the anesthesiology staff shall be present in person for crucial periods of surgical procedures and anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

Pharmacy and Therapeutics Committee (P & T Committee)

The P & T committee shall be appointed in conformity with the medical staff bylaws and have representation from medical staff, nursing, pharmacy department, and the hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(A) Review the appropriateness, safety, and effectiveness of the prophylactic empiric and therapeutic use of drugs, including antibiotics, through the analysis of individual or aggregate patterns of drug practice.

(B) Consider the welfare of patients as well as education, research and economic factors when analyzing the utilization of drugs and related products.

(C) Advise on the use and control of experimental drugs.

(D) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.

(E) Review all significant untoward drug reactions.

(F) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.

(G) Maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken, and report these at least quarterly to the medical staff administrative committee.

(H) Create sub-committees, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulatory sub-committee; antibiotic usage sub-committee; medication safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.

(I) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.

(J) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.

(K) Provide guidance to the therapeutic drug monitoring service at the CHRI.

(L) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive subcommittee.

Transfusion and Isoimmunization Committee

(A) The transfusion and isoimmunization committee has representation from physicians of the clinical departments frequently using blood products, nursing, transfusion service, and hospital administration. The majority of members shall be members of the medical staff. The committee shall meet at least quarterly and carry out the following duties:

(1) Evaluate the appropriateness of all transfusions, including the use of whole blood and blood components.

(2) Evaluate all confirmed or suspected transfusion reactions.

(3) Develop and recommend to the medical staff administrative committee policies and procedures relating to the distribution, use, handling, and administration of blood and blood components.

(4) Review the adequacy of transfusion services to meet the needs of patients.

(5) Review ordering practices for blood and blood products.

(6) Provide a liaison between the clinical departments, nursing services, hospital administration, and the transfusion service.

(7) Use clinically valid criteria for screening and more intensive evaluation of known or suspected problems in blood usage.

(8) Keep written records of meetings, conclusions, recommendations, and actions taken, and the results of actions taken, and make these available to each committee member and to the medical staff administrative committee.

(B) Each member of the medical staff shall conform to the policies established by the transfusion committee, including the following:

(1) All pregnant patients admitted for delivery or abortion shall be tested for Rh antigen.

(2) No medication may be added to blood or blood products.

Infection Control Committee

(A) The committee members shall be appointed and shall also include representation from nursing, environmental services, and hospital administration. The chairperson will be a physician with experience and/or training in infectious diseases and carry out the following duties.

(1) Oversee surveillance and institute any recommendations necessary for investigation, prevention, and containment of nosocomial and clinical infectious diseases of both patients and staff at all facilities operated by CHRI and subject to TJC standards.

(2) The chairperson of the committee and the hospital epidemiologist, in consultation with the director of medical affairs of the CHRI, will take necessary actions to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

Quality Leadership Council

The quality leadership council shall consist of members appointed pursuant to the university hospital's medical staff bylaws, and shall include the senior vice president for health sciences, the dean of the college of medicine and the chairperson of the professional affairs committee of the Wexner medical center board as ex officio members without a vote, and the director of medical affairs and chief of staff as voting members. The chief quality officer shall be the chairperson of the quality leadership council. The quality leadership council shall authorize policy groups to be formed to accomplish necessary hospital and medical staff functions on behalf of the CHRI and university hospitals.

CHRI representatives on the quality leadership council shall be appointed as provided in the CHRI bylaws.

(A) Duties include:

(1) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery systems.

(2) To serve as the oversight council for the clinical quality management and patient safety plan.

(3) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(B) Clinical quality and patient safety committee.

(1) Composition.

The members shall include physicians from various clinical areas and support services, the director of clinical quality management policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Coordinate the quality management related activities of the clinical sections or departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and immunization, and other medical staff and hospital committees.

(b) Implement clinical improvement programs to achieve the goals of the CHRI quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.

(c) Review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical section or department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

(d) Serve as liaison between the CHRI and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.

(e) Make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the CHRI.

(f) Hear and determine issues concerning the quality of patient care rendered by members of the medical staff and hospitals staff, make appropriate recommendations and evaluate action plans when appropriate to the director of medical affairs, the chief of a clinical section or department, or hospitals administration.

(g) Appoint ad-hoc interdisciplinary teams to address hospital-wide quality management plan.

(h) Annually review and revise as necessary the hospital-wide clinical quality management plan.

(i) Report and coordinate with the quality leadership council all quality improvement initiatives.

(C) Clinical resource utilization policy group.

(1) Composition.

The members shall include physicians from various areas and support services, the director of clinical resource utilization policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Promote the most efficient and effective use of hospital facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.

(b) Formulate and maintain a written resource management review plan for hospitals consistent with applicable governmental regulations and accreditation requirements.

(c) Conduct resource management studies by clinical service or by disease entity as requested or in response to variation from benchmark data would indicate.

(d) Report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements when the opportunity exists to improve the resource management.

(D) Clinical Practice Guideline Committee.

(1) Composition.

The members shall include physicians from various areas and support services, the director of the practice guidelines policy group, and representation from nursing and hospitals administration. The chairperson of the policy group will be a physician.

(2) Duties.

(a) Oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e. clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the CHRI. Planning should be based on the prioritization criteria approved by the leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guidelines.

(b) To report regularly to the quality leadership council for approval of all new and periodically reviewed evidence-based medicine resources for use within the CHRI.

(c) Oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the CHRI. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to the quality leadership council for approval. All other computerized value enhancement for approval. All other computerized ordersets and clinical rules should be forwarded to the quality leadership council for information.

(d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.

(e) Oversee ongoing education of the medical staff (including specifically limited staff) and other appropriate hospital staff on the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.

(f) Regularly report a summary of all actions to the quality leadership council.

(Board approval dates: 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 4/6/2016, 5/18/2021)

12 Standards of practice.

(A) Surgical schedules shall be reviewed by the attending surgeon prior to the day of surgery. Attending surgeons must notify the operating room prior to the first scheduled case that they are physically present in the hospital and immediately available to participate in the case. Attending surgeons may accomplish this by being physically present in the operating room or by calling the operating room to notify the staff of such immediate availability. The operating room must be informed of the attending surgeon's availability prior to anesthetizing the patient. The only exception is an emergency situation, where waiting might compromise the patient's safety.

(B) All medical staff members must abide by the quality and safety protocols that may be defined by the medical staff administrative committee and the Wexner medical center board.

(C) Inpatients must be seen daily by an attending physician, with no exceptions, to provide the opportunity of answering patient and family questions.

(Board approval dates: 4/8/2011, 4/6/2016)

13 Mechanism for changing rules and regulations.

(A) These rules and regulations may be amended pursuant to rule 3335-111-12 of the Administrative Code.

(B) Amendments so accepted shall become effective when approved by the Ohio state university Wexner medical center board.

(C) These rules and regulations shall not conflict with the rules and regulations of the board of trustees of the Ohio state university.

(D) Each member of the medical staff and those having delineated clinical privileges shall have access to an electronic copy of the rules and regulations upon finalization of the approved amendment changes.

(Board approval dates: 11/4/2005, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

14 Adoption of the rules and regulations.

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in successive order to the following: the professional affairs committee of the Wexner medical center board if it meets prior to the next scheduled Wexner medical center board meeting, and the Wexner medical center board.

(Board approval dates: 7/7/2006, 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)

15 Sanctions.

Each member of the medical staff shall abide by policies approved by the medical staff administrative committee of the CHRI. Failure to abide may result in suspension of some or all hospital privileges.

(Board approval dates: 9/18/2009, 2/11/2011, 4/8/2011, 4/6/2016)