



**MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals
as of February 8, 2022**

84-01 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: 11/4/2005, 8/31/2012, 4/6/2016)

84-02 Admission procedures.

- (A) Except in an emergency, in the interest of assignment to the appropriate service area, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated by the patient's attending physician or other licensed healthcare professional who is appropriately credentialed by the hospital and under the supervision of the collaborating 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 shall warn responsible hospital personnel of any tendency of any patient to try 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) In the event that a patient is presented to the hospital with an illness, emotional problem, or condition which is the result of alcoholism or drug abuse and which substantially impairs the patient's affairs and social relationships (including indications of self-harm such as attempted suicide or suicidal gestures), it is the responsibility of the attending physician to provide for a proper comprehensive plan of care, including emergency care.

If a patient with a mental disorder is treated in the hospital for a medical condition, it shall be the responsibility of the attending physician to notify hospital or medical staff personnel of the existence of the 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.

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It shall also be the attending physician's responsibility to address the underlying mental health or substance abuse problem and when indicated, refer the patient to an appropriate or dedicated facility dealing with alcoholism/drug abuse or mental health problems.

(Board approval dates: 9/6/2002, 9/18/2009, 4/6/2016)

84-03 Attending assignment.

- (A) All patients entering university hospitals who have not requested the services of a member of the medical staff of university hospitals to be responsible for their care and treatment while a patient therein shall be assigned to a member of the attending staff of the clinical division or service concerned with the treatment of the disease, injury, or condition which necessitated the admission of the patient to university hospitals. This shall also apply to the transfer of patients within the clinical divisions or services of the university hospitals.
- (B) Alternate attending medical staff member coverage. Each member of the medical staff shall designate on his or her medical staff application one or more members of the attending or courtesy 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 chief of the medical staff member's clinical department or the medical director 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. If the chief of the medical staff member's clinical department or the medical director or his designee is unavailable, the emergency department physician on duty is responsible for arranging appropriate medical coverage until the attending medical staff member is available to care for the patient.

(Board approval dates: 9/6/2002, 3/5/2003, 4/6/2016)

84-04 Consultations.

- (A) Consultation requirements.

When a patient care problem is identified that requires intervention during the hospital stay that is outside the attending or courtesy medical staff member's area of training and experience, it is the responsibility of the attending or courtesy medical staff member or his or her designee, who is appropriately credentialed by the hospital, 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 ten a.m., the consult shall occur on the same business day. If a consultation is ordered after ten a.m., the consult shall occur within twenty-four hours. Irrespective of consultations each patient is continuously assessed and reassessed and his or her plan for care is modified as necessary.

- (B) Responsibility to monitor consultations.

It is the duty of the medical staff through its clinical departmental chiefs 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 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

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procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(Board approval dates: 9/6/2002, 11/4/2005, 6/6/2008, 9/18/2009, 4/8/2011, 4/6/2016)

84-05 Privileges for giving orders.

(A) Definition of "patient orders."

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. 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 non-verbal order, refer to both written and electronically entered orders.

(B) Electronic ordering.

Electronic orders are equivalent and have the same force 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.

(C) Responsible medical practitioner.

The licensed physician, dentist, podiatrist, or psychologist (under medical doctor supervision) member of the medical staff responsible for the care and treatment of the patient is responsible for all orders for the patient. Attending and courtesy medical staff may designate members of the limited staff, or other licensed healthcare professional 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, podiatrist, psychologist, or designated limited staff member who has the right of practice of medicine, dentistry, psychology, or podiatry, and who is responsible for that patient's care. All non-verbal orders must be authenticated by the medical practitioner prior to the execution of the order(s) by the hospital or outpatient nursing staff or other professional groups.

(D) Telephone and verbal orders.

Telephone and verbal orders may be given by the responsible attending physician, dentist, podiatrist, psychologist, member of the limited staff, or other licensed healthcare professional with appropriate clinical privileges only to health care providers who have been approved in writing by title or category by the medical director and each chief of the clinical service where they shall 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 hospitals, or by the customary medical staff credentialing process when the provider is not an employee of the hospitals. Lists of the approved titles or categories of providers shall be maintained by the chief medical officer. 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 the approved health care provider to whom it is given as "verbal order by," or "V. O. or T. O. by," recording the licensed healthcare practitioner's name and the time of the order. All verbal orders for D.E.A. schedule II controlled substances, patient seclusion, or patient restraint must be authenticated within twenty-four hours by signature of a licensed physician, dentist,

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podiatrist, psychologist, or designated limited staff member, or other licensed healthcare professional 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 a licensed physician, dentist, podiatrist, psychologist, limited staff member, or other licensed healthcare professional with appropriate privileges.

(E) Standing orders.

Standing orders for medications are only approved in emergency situations. All other standing orders must 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.

(F) 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 professional with appropriate privileges before becoming effective.

(G) 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, psychologist, 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.

(H) Change of nursing service.

"Change of nursing service" means official and physical movement (transfer) of a patient from any permanent care unit to another with or without change in attending physician, dentist, psychologist, or podiatrist or clinical service. Orders effective before transfer must be reviewed, renewed, rewritten or reentered upon transfer by the 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 shall remain in effect until new orders are available. This should be done within eight hours of transfer.

(I) Transfer of clinical service.

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 of nursing service" 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 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., thoracic surgery service."
- (2) Transfer of service may be completed only by the receiving service writing or electronically entering an order to the effect "accept in transfer (or admission) to Dr., cardiology service."

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Orders effective before the transfer must be renewed, rewritten or reentered upon transfer by the responsible medical practitioner, a limited staff member, or other licensed healthcare professional with appropriate 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.

- (J) Patient orders and the "covering" medical practitioner.

"Coverage" of patient responsibilities for another physician, dentist, psychologist, 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, psychologist, or podiatrist and patient.

- (K) Hospital discharge/readmission orders.

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

- (L) Orders in emergency vehicles.

These rules and regulations apply to university hospital's owned and/or manned emergency care and retrieval vehicles.

- (M) Do not resuscitate order.

Do not resuscitate orders must be written or electronically entered in strict compliance with the comprehensive policy guidelines published by the medical staff administrative committee and hospital administration. See hospital policy 03-24.

- (N) Hospital admission/observation orders.

Hospital admission/observation requires an appropriate level of care (ALOC) designating the patient as an inpatient or an outpatient (observation). The appropriate level of care (ALOC) order may be written and 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 privileges, 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 physician, limited staff member or other licensed healthcare practitioner with appropriate clinical privileges and under the supervision of the collaborating physician.

(Board approval dates: 9/6/2002, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 6/6/2008, 9/18/2009 4/8/2011, 4/6/2016, 9/2/2016)

84-06 Death and autopsy procedures.

- (A) Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written consent, permission, or direction as prescribed by the laws of Ohio.

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- (B) All autopsies shall be performed by an attending pathologist with hospital privileges or other attending practitioner who is qualified to perform autopsies. The attending pathologist or his or her designee, who is appropriately credentialed by the hospital, shall have the responsibility of informing the patient's attending physician or designee, who is appropriately credentialed by the hospital, that a proper consent for the performance of an autopsy has been obtained. The anticipated time for the autopsy shall also be reported at this time.
- (C) 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. When the coroner elects not to perform an autopsy, a request for 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 infectious 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.
- (D) 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: 9/6/2002, 11/2/2007, 9/18/2009, 4/6/2016)

84-07 Disaster plan.

A civil, military, natural emergency or disaster, may be declared by the medical director and executive director of university hospitals or their designees. The comprehensive planning for triage and treatments of patients presenting for urgent or emergency care shall be the responsibility of the medical director. The departments of emergency medicine and the department of surgery shall be charged with the primary responsibility for trauma patient care.

Upon order of the medical director, patients may be discharged, transferred to another hospital, or moved to other health care facilities in order to make more room for critical ill or injured patients. The medical

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director and the executive director may participate in local or regional emergency or disaster plans as may be appropriate to save lives and provide adequate medical care and treatment.

(Board approval dates: 9/6/2002, 4/6/2016)

84-08 Emergency care.

(A) Level of services

The emergency department offers level I comprehensive care twenty-four hours/day. Emergency medical services are provided to any patient requiring appropriate care in the university hospitals emergency department, university hospitals east emergency department or for any pregnant patient in the university hospitals labor and delivery triage unit that provides care twenty-four hours/day. No patient shall be arbitrarily transferred to another hospital if university hospitals have the capability of proceeding with the necessary care.

(B) Organization

The respective department/unit shall be directed by a physician member of the attending medical staff, known as the medical director. An acting director shall be designated and authorized to perform the functions of the director when the director is not available. Both shall be board certified or eligible in emergency medicine and shall have at least three years training or experience.

(C) Coverage

All patient care is the responsibility of attending, courtesy A and community affiliate medical staff. Medical coverage may be provided by limited staff under supervision by the attending, or courtesy A members of the medical staff. Medical screening examinations shall be performed by members of the medical staff or his/her designee appropriately credentialed by the hospital and under the supervision of the collaborating medical staff member. When a consultation or arrangement for admission is referred to specialty service, the member of the attending medical staff to whom the consult is directed shall be notified of the findings by the limited staff and concur in the treatment plan and disposition of the patient. This shall be recorded in the electronic medical record. When limited staff are unavailable or unable to provide the appropriate level of services, the attending staff member shall be contacted directly by the emergency department staff physician for provision of necessary and appropriate care (see 3335-43-07 (B) of the Administrative Code).

(D) Policies

Written policies in each emergency department and in the labor and delivery triage unit shall be developed by the medical director in consultation with appropriate services. These shall be reviewed at least annually and approved by the medical staff or its representatives and the hospital administration. These shall be revised as needed and dated at time of last review.

(E) Records

Records shall be maintained on all patients in accordance with the rules of the Joint Commission for a level I service. The emergency record shall be incorporated into the permanent hospital electronic medical record.

(Board approval dates: 9/6/2002, 9/18/2009, 4/6/2016)

84-09 Surgical case review.

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Surgical case review shall be performed as part of the hospital's peer review and quality improvement activity on an ongoing basis, at least monthly, by each department/division (as appropriate) regularly doing surgical procedures. 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 performing surgical procedures 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 division, available to the medical director or the director's designee and the clinical department chairperson or their designee.

(Board approval dates: 9/6/2002, 4/6/2016)

84-10 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, such as the foreskin from the circumcision of a newborn infant;
- (F) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and
- (G) Teeth, provided the number, including fragments, is recorded in the medical record.

(Board approval dates: 9/6/2002, 4/6/2016)

84-11 Committees and policy groups.

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

(Board approval dates: 9/6/2002, 4/6/2016)

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84-12 Medical records.

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

(1) Medical Record contents

The attending medical staff member shall be ultimately responsible for the preparation of a complete medical record of 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 in an electronic or paper form. This record shall include the following elements as it applies to the patient encounter:

- (a) Identification and demographic data including the patient's race and ethnicity.
- (b) The patient's language and communication needs.
- (c) Emergency care provided to the patient prior to arrival, if any.
- (d) The legal status of patients receiving mental health services.
- (e) Evidence of known advance directives.
- (f) Statement of present complaint.
- (g) History and physical examination.
- (h) Any patient generated information.
- (i) Provisional diagnosis.
- (j) Documentation of informed consent when required.
- (k) Any and all orders related to the patient's care.
- (l) Special reports, as those from:
 - (i) The clinical laboratory, including examination of tissues and autopsy findings, when applicable.
 - (ii) Signed and dated reports of nuclear medicine interpretations, consultations, and procedures.
 - (iii) The radiology department.
 - (iv) Consultants.
- (m) Medical and surgical treatments.
- (n) Progress notes.
- (o) Pre-sedation or pre-anesthesia assessment and plans of care for patients receiving anesthesia.
- (p) An intra-operative anesthesia record.

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- (q) Postoperative documentation records, including 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
 - (r) 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.
 - (s) A post-anesthesia follow-up report written within forty-eight hours after surgery.
 - (t) Reassessments and revisions of the treatment plan.
 - (u) Every dose of medication administered and any adverse drug reaction.
 - (v) Every medication dispensed to an inpatient at discharge.
 - (w) Summary and final diagnosis as verified by the attending medical staff member's signature.
 - (x) Discharge disposition, condition of patient at discharge, and instructions given at that time and the plan for follow up care.
 - (y) Any referrals and communications made to external or internal providers and to community agencies.
 - (z) Any records of communication with the patient made by telephone or email or patient electronic portal.
- (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 by the hospital, 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 completed 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 preoperative and postoperative 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 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 ten 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 and add-on cases. The attending medical staff member will only be allowed to schedule emergency cases until all delinquent operative/procedure reports are completed. All emergency cases scheduled by suspended medical staff

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members are subject to the review of the medical director and will be reported to the suspended medical staff members' chief of the clinical department and the medical director by the operating room staff. 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. In the event that the patient's condition has not changed, and no diagnostic studies have been done, 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 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) Office visit encounters shall be closed within ten days of the patient's visit.
- (f) All entries not previously defined must be signed within ten 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.

(3) Discharges

- (a) Patients may not be discharged without a written or electronically entered discharge order from the appropriately credentialed, responsible medical staff member, 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 verifying the principal diagnosis, secondary diagnoses, 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 medical staff member within forty-eight hours of availability.

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- (d) The discharge summary must contain the following elements:
 - i. hospital course including reason for hospitalization and significant findings upon admission;
 - ii. principal and secondary diagnoses or provisional diagnoses;
 - iii. relevant diagnostic test results;
 - iiii. procedures performed and care, treatment and services provided;
 - ivi. condition at 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 appointments;
 - viii. plans for follow up care and communication, and the instructions provided to the patient.
- (e) A complete summary is required on all patients who expire, regardless of length of stay.
- (f) All medical records must be completed by the attending medical staff member or, when applicable, the limited staff member or other licensed healthcare professional within twenty-one days of discharge of the patient.
- (g) Attending medical staff members shall be notified prior to suspension for all incomplete records. After notification, attending medical 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.
- (h) Records which are incomplete, more 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 including pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc. 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 and security.

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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. Such documentation shall be in compliance with the hospitals policy and procedure manual section 03-27.
- (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 define the criteria for record completion subject to the 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, timed and dated promptly by the person, identified by name and discipline, 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 system.
- (d) Signature stamps may not be used in the medical record.

(Board approval dates: 9/6/2002, 3/5/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 11/2/2007, 6/6/2008, 9/18/2009, 4/8/2011, 8/31/2012, 4/6/2016, 9/2/2016, 4/6/2018, 5/31/2019, 2/8/2022)

84-13 Operating room committee.

- (A) The operating room committee shall have representation from clinical departments using the

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operating room, the medical director of the operating room, nursing, director of the operating room, the operating room coordinator, and hospital administration. The committee is appointed by the medical director in consultation with the executive director of university hospitals. The committee shall meet at least quarterly and carry out the following duties:

- (1) Insure that surgical privileges have been delineated for each member of the medical staff who uses the operating rooms.
 - (2) Develop written policies and procedures concerning the scope and provision of care in the surgical suite in cooperation with the departments and services concerned.
 - (3) Consider problems in operating room functions brought to its attention by any of its members.
 - (4) Monitor medical staff compliance with operating room policies established for patient safety, infection control, and smooth functioning of the operating rooms.
 - (5) Develop and make recommendations to the medical staff administrative committee regarding conduct of medical staff in the operating rooms.
 - (6) Maintain written records of actions taken, and results of those actions, and make these available to each committee member, the vice president for health sciences, the medical director, the executive director, and the associate executive directors.
 - (7) The operating room committee shall be a hospital committee and be appointed in accordance with policies and procedures of the Ohio state Wexner medical center board.
- (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 attending surgical staff shall be present in person during surgical procedures and a member of the attending anesthesiology staff shall be present in person during anesthetization, shall be familiar with the progress of the procedure, and be immediately available at all times during the procedure.

(Board approval dates: 9/6/2002, 5/14/2010, 4/6/2016)

84-14 Pharmacy and therapeutics committee.

The pharmacy and therapeutics and drug utilization committee shall be appointed in conformity with these bylaws and have representation from medical staff, nursing, pharmacy department, 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:

- (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) Provide the medical and hospitals staff with information and advice concerning the proper use of drugs and related products. Monitor and evaluate those drugs which are most prescribed, known to present problems or risks to patients, and which constitute a critical part of a patient's specific diagnosis, condition or procedure.
- (C) Consider the welfare of patients as well as education, research and economic factors when analyzing

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the utilization of drugs and related products.

- (D) Advise on the use and control of experimental drugs.
- (E) Develop or approve policies and procedures relating to the selection, distribution, use, handling, and administration of drugs and diagnostic testing materials.
- (F) Review all significant untoward drug reactions.
- (G) Maintain the Formulary of Accepted Drugs with review of proposed additions and deletions and review of use of non-formulary drugs within the institution.
- (H) 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.
- (I) Create sub-committees, as follows: pharmacy and therapeutic and drug utilization executive sub-committee; formulary sub-committee; antibiotic usage sub-committee; medical safety and policy sub-committee; and the therapeutic drug monitoring sub-committee.
- (J) The therapeutic drug utilization monitoring sub-committee shall:
 - (1) Establish methods by which serum blood levels may be used to improve the therapeutic activity of drugs.
 - (2) Establish programs to educate health care providers to the appropriate methods of monitoring the therapeutic effect in drugs via serum drug assays.
 - (3) Provide guidance to the therapeutic drug monitoring service at university hospitals.
 - (4) Recommend the development of policies and procedures to the pharmacy and therapeutic and drug utilization executive sub-committee.

(Board approval dates: 4/7/2000, 9/6/2002, 4/6/2016)

84-15 Transfusion and isoimmunization committee.

- (A) The transfusion and isoimmunization committee shall be appointed pursuant to these bylaws and include 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,

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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 and isoimmunization 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.

(Board approval dates: 4/7/2000, 9/6/2002, 6/4/2004, 4/6/2016)

84-16 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 in 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)

84-17 Mechanism for changing rules and regulations.

- (A) These rules and regulations may be amended pursuant to rule 3335-43-13 of the Administrative Code.
- (B) Amendments so accepted shall become effective when approved by the Ohio state 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: 4/8/2011, 4/6/2016)

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84-18 Adoption of the rules and regulations.

These rules and regulations shall be adopted by the medical staff administrative committee and forwarded for approval in the same fashion as provided in section 84-16.

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

84-19 Sanctions.

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

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