

**NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO**

MEDICAL STAFF

RULES AND REGULATIONS MANUAL

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ARTICLE 5: RULES AND REGULATIONS MANUAL	PAGE #
5.1. Admission and Discharge of Patients	3
5.2. General Rules	6
5.3. Orders	12
5.4. Medical Records	14
5.5. Rules for Operating Room	20
5.6. Rules for Dental Care	23
5.7. Rules for Podiatric Care	23
5.8. Rules for Emergency Department Care	24
5.9. Rules for Reporting and Review of Practices of HBeAg-Positive or HIV Antibody	26
5.10. Guidelines for Written Informed Consent	28
5.11. Qualified Medical Personnel to Perform Medical Screening for Emergency Medical Conditions	31

ARTICLE 5: RULES AND REGULATIONS

These Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Hospital credentialed person. These Rules and Regulations shall be periodically reviewed and recommended for updating by the Bylaws Committee.

5.1. Admission and Discharge of Patients

- A. The Hospital shall accept patients for care and treatment of all types of diseases.
- B. Patients may be admitted at Nationwide Children's Hospital only by members of the Medical Staff. At the time of admission, the attending physician will be identified on the admission order.
- C. Except in an emergency situation, no patient shall be admitted to the Hospital until after a provisional or tentative diagnosis has been recorded. In the case of an emergency such a statement shall be recorded as soon as possible.
- D. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.
- E. Patients being admitted through the Emergency Department will be asked if they have a personal physician or dentist. In such cases, it is the responsibility of the Emergency Department staff to contact their practitioner to determine his/her preference of consultant or to assume the care of the patient himself/herself.
- F. No patient shall be assigned to the care of a staff member without the consent of that practitioner or his/her representative.
- G. All patients not requesting a specific practitioner or not having been referred to a specific consultant by their personal practitioner shall be attended by medical staff with clinical privileges as assigned by the department or section concerned in the treatment of the disease which necessitated admission.
- H. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of other patients.
- I. Current bed assignment policy by sex, age and type of patient shall be available in the admitting department.
- J. The chief admitting clerk will admit patients on the basis of the following order of priorities:

1. Emergency Admissions - within twenty-four (24) hours after the emergency admission the attending physician shall record on the chart the justification for this admission.
 2. Pre-Operative Admissions - includes scheduled surgeries.
 3. Urgent Admissions - are those which do not warrant immediate admissions; but because of the nature of the disease, the admission should not wait for more than a week.
 4. Routine Admissions - includes elective admissions of all services.
 5. Admission of patients to I.C.U. shall be reviewed by the chief resident involved in consultation with the I.C.U. Triad practitioner or designee.
- K. The attending physician is required to document (certify) the need for continued Hospitalization at intervals consistent with quality standards of care, but not less frequent than those intervals specified by governmental regulations and third party payers.
- L. Patients shall be discharged only on written or phone order (countersigned by the responsible practitioner within 24 hours) of the attending physician or his/her house staff representative. Should a patient leave the Hospital against the advice of the attending physician or without proper discharge, the custodial parent/or other legally authorized guardian shall be requested to sign a release statement. A notation shall be made on the patient's record.
- M. Patients with infectious diseases will be assigned rooms and isolated according to Hospital policy.
- N. Transfer Policies:
1. A move from one room to another on the same unit does not require notice to the practitioner. However, any move from one area (unit or floor) to another requires a written order by the attending physician or designee and the attending physician will be identified and notified on the receiving unit.
 2. The patient will be moved to the Isolation Unit if recommended by written order of the attending physician or the practitioner director of Epidemiology.
 3. If a house officer orders any patient to be moved to another area, it shall be his/her responsibility to notify the attending physician.

4. Transfer of a patient from another Hospital to Nationwide Children's Hospital requires that the "Emergency Transfer Form" accompany the patient. The parent or other legally authorized guardian, will indicate their approval by signing a Nationwide Children's Hospital "Consent Form".
5. In the event that a patient is transported to another facility for special treatment or services, the parent or other legally authorized guardian, must give written approval on the Nationwide Children's Hospital "Consent Form".
6. In time of medical disaster, the Hospital Disaster Plan shall be followed for admission, discharge and transfer of patients.

5.2. General Rules

- A. Patients may be treated only by persons who have submitted proper credentials and have been duly appointed to membership on the Medical Staff, or are otherwise authorized to provide treatment in accordance with the Medical Staff Credentials Manual and the Medical Staff Bylaws Manual.
- B. Patients shall be attended by medical staff with clinical privileges and shall be assigned to practitioners in appropriate section or department concerned in the treatment of the disease which necessitated admission. Names of practitioners shall be furnished to the Admitting Office by the chief of each service. The service to which such a patient shall be assigned should be indicated by the admitting practitioner.
- C. Each member of the staff shall name an alternate whose practice is in the immediate vicinity and with whom prior arrangements have been made to assure appropriate professional care for his/her patients in his/her absence. The alternate must be a member of the staff. Failing the above, the Chief Medical Officer shall have authority to assign any member of the Active staff to the case.
- D. Medical History and Physical Examination
 - 1. General Requirements
 - a. A history and physical must be completed for every inpatient admission using the history and physical note type in Epic.
 - b. In the case of general anesthesia prior to outpatient surgery or imaging studies (MRI, CAT, etc) the attending anesthesiologist may perform the history and physical and the anesthesia pre-evaluation and complete the Anesthesia History and Assessment form reflecting the history and physical in lieu of either the Outpatient Admission Assessment or the Admission Assessment. Patients receiving general anesthesia for imaging studies will be discharged from the PACU to home by the attending anesthesiologist. Patients undergoing an outpatient interventional radiological procedure will be discharged from sedation by the attending radiologist.
 - c. In the event of an emergency surgical situation, the responsible practitioner must, if possible, document the emergency and record a progress or admission note describing a brief history, appropriate physical findings and the preoperative diagnosis in the medical record before surgery. The history and physical must be completed as soon as possible after surgery but, in no event, later than twenty-four (24) hours after admission or registration.

- d. With the exception of emergency situations, when the history and physical is not completed and documented in the patient's medical record before surgery or a procedure requiring anesthesia, the operation or procedure will not proceed. In the event a surgery is canceled, the reason shall be clearly noted in the progress notes.

2. Content of the History and Physical

- a. The Medical Staff shall monitor the quality of history and physicals. History and physical content may vary by setting or level of care, treatment and services but both inpatient and outpatient history and physicals should, at a minimum, including the following:
 - (1) Chief complaint;
 - (2) History of present illness, including when appropriate, assessment of the patient's emotional, behavioral, and social history;
 - (3) Relevant past medical/surgical history and family history;
 - (4) Review of immunization records;
 - (5) Menstrual and obstetric history for females;
 - (6) Drug sensitivities/allergies;
 - (7) Current medications;
 - (8) If pertinent, laboratory, radiologic and other diagnostic results;
 - (9) Additional criteria for pediatric patients: head circumference (physical) for infants/children; developmental assessment (physical); education/social status and needs (history); patient and family expectation of care/outcome (history); family and caregiver legal status (history); and
 - (10) Additional criteria for incompetent patients: family and caregiver legal status, expectations for, and involvement in the assessment, treatment and/or continuous care of an incompetent patient.
- b. Medical History. The medical history shall include:
 - (1) Chief complaint;
 - (2) History of present illness, including when appropriate, assessment of the patient's emotional, behavioral, and social history;
 - (3) Relevant past medical/surgical history and family history;
 - (4) Review of immunization records;
 - (5) Menstrual and obstetric history for females;
 - (6) Drug sensitivities/allergies;
 - (7) Current medications;
 - (8) If pertinent, laboratory, radiologic and other diagnostic results;
 - (9) Additional criteria for pediatric patients: head circumference (physical) for infants/children; developmental assessment (physical); education/social status and needs (history); patient and family expectation of care/outcome (history); family and caregiver legal status (history); and
 - (10) Additional criteria for incompetent patients: family and caregiver legal status, expectations for, and involvement in the assessment, treatment and/or continuous care of an incompetent patient.

- c. Physical Examination. The physical examination shall include:
 - (1) Vital signs;
 - (2) Height and weight; and
 - (3) Documentation of exam of ears, eyes, nose, throat, skin, neck, lungs, heart, neurologic, genitalia, abdomen, extremities.
- E. Dentists, podiatrists and psychologists are responsible for the part of their patient's history and physical examination that relates to their respective specialty.
- F. When a medical or surgical consult is needed, only members of the Medical Staff or a collaborating allied health professional (AHP) may perform consultations. Routine consultations may be initiated by a medical student, resident or fellow but an attending consultant must complete the consultation form within twenty-four (24) hours of notification. The twenty-four (24) hour rule may be waived for routine consults on weekends and holidays. Such elective delays require communication between the consultant and the requesting attending physician. Screening consults (e.g. neonatal retinal and hearing exams, rehab consults for trauma victims) may be completed after twenty-four (24) hours when developmentally or medically more appropriate. These consults may be completed at the discretion of the consultant with appropriate notification of the patient care team.

Except in emergency, consultation is required in the following situations:

1. In situations where specific skills of other persons may be needed;
2. When requested by the patient or his/her family when medically indicated during the patient's admission.

A satisfactory consultation includes examination of the patient and the record and a recorded opinion within twenty-four (24) hours after the consultation is performed and signed by the consultant which is made a part of the record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to operation.

If, in the opinion of an attending physician, a true emergency exists, wherein life, limb or general health of a patient could be in jeopardy, and if the opinion of another attending or specialty is required, direct attending physician to attending physician contact by phone should be established. It is expected that the consultant contacted will immediately respond or dispatch a qualified physician or AHP.

- G. The attending physician is primarily responsible for requesting inpatient consultation when indicated. Except in an emergency, the attending physician, or his/her designee, will provide authorization for a consult on his/her patient. An order must be completed by the requesting attending physician or designee as soon as possible.

Consultations in the Emergency Department may be provided to patients on request of either members of the house staff or the attending staff of the Emergency Department or the specialty services.

- H. The consult note type should be used for all new and follow-up documentation for inpatient and Emergency Department consultations.
- I. In all circumstances, consult notes entered by students, residents, or fellows must be authenticated by the supervising attending physician.
- J. An emergency condition that warrants consultation without the attending physician's (or his/her designee) request and/or order includes any patient with a deteriorating medical condition. If the patient is in cardiorespiratory arrest outside of the intensive care units, the "Code Blue" team must be activated.

For any situation in which a patient's safety and/or well being are at risk (e.g. patients admitted to the general medical and surgical floors with unstable vital signs, unfamiliar clinical conditions, changing mental status, new or prolonged seizure, or pain or agitation unresponsive to standard measures), any member of the Hospital staff, parent(s), or legal guardian may contact the Assessment and Consultation Team (ACT). The physician member of that team is permitted to consult and write orders on the patient by virtue of the team activation.

ACT will communicate directly to the attending physician with recommendations. If the attending physician agrees, therapy or transfer is initiated; if attending physician disagrees, attending's plan is used and note left on chart by ACT; if attending can't be reached ACT's recommendations shall be implemented.

- K. Consultations not referred to a specific practitioner, AHP, psychologist or podiatrist will be referred to the person on call for the service. A consultant may defer or reject a consult request only after direct communications with the attending physician. When this occurs, the emergency consult request will be cancelled by the requesting staff and/or another consult ordered.
- L. If a healthcare professional has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who in turn may refer the matter to the Chief Nursing Officer and/or Chief Medical Officer.

If warranted, the Chief Nursing Officer and/or Chief Medical Officer may bring the matter to the attention of the chief of the department or section wherein the practitioner caring for the patient has clinical privileges. Where circumstances are such as to justify such action, the chief of the department may request a consultation.

- M. Minor patients may not be removed from the Hospital premises except in an emergency without the approval of the custodial parent or other legally authorized guardian, and attending physician, or his/her designee.
- N. Procedural guidelines relating to medical practice and concerning specific clinical departments and special care units shall be reviewed and approved by the appropriate Medical Staff committees.
- O. Because Nationwide Children's Hospital is a teaching institution, all patients shall be considered available for teaching purposes except when the attending physician specifically designates otherwise.
- P. In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. An entry must be made confirming the patient's death in the medical record and shall be signed by the attending physician or his/her designee before the body is released. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death.
- Q. It shall be one of the duties of all staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. Except for cases appropriately referred to the coroner, all autopsies shall be performed by the Hospital pathologist or by a practitioner delegated this responsibility.
- R. Consent for organ donation of all or part of the decedent's body will be requested when the patient, who is a suitable candidate, dies while under the care of Nationwide Children's Hospital. To comply with Section 2108.021 of the Ohio Revised Code and the Federal Social Security Act, Section 1138 (a), human organs and tissue are defined as the human heart, kidney, liver, lung, pancreas, bone, bone marrow, eye, skin and any other organ or tissue exclusive of blood. The Request for Anatomical Gift form is available on all critical care units and in the Expiration Packet.
- S. For the protection of patients, the medical and nursing staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal or self-destructive patient;

1. Any patient known or suspected to be suicidal in intent shall be admitted to the Hospital with the understanding that consultation from psychiatry or psychology or both will be used as an aid to best plan for the care of the patient, other patients, staff, and personnel.
 2. In the event that a patient admitted to the Hospital is then or later suspected of being suicidal or self-destructive in other ways, prompt consultation with the psychiatry or psychology services or both shall be obtained. Should a patient show indications of continued emotional disturbance such that there is fear of suicide or continued self-destruction, measures shall be taken to protect the patient, other patients, and staff. If, in the judgment of the attending physician, the facilities offered by Nationwide Children's Hospital are inadequate to protect the patient or other patients, appropriate steps should be taken to transfer the patient to a more appropriate facility.
- T. It is the responsibility of each staff member to bring to the attention of the President of the Medical Staff any situation which causes question regarding the physical or mental health of another staff member.
- U. The attending physician is primarily responsible for ensuring compliance with the patient's Self-Determination/Advance Directive, when applicable, and in accordance with the Hospital's administrative policy regarding same.
- V. Patients shall be afforded their rights to informed decisions about their care. If an Advanced Directive exists it will be reviewed upon change of condition (transfer to or from critical care) or with initiation or rescind of an Allowing Natural Death order.

5.3. Orders

- A. Orders may be entered by the attending physician, house staff or other qualified practitioner, including advanced practice nurse (APN) who may enter orders in accordance with their scope of practice, standard care arrangement, and job description. Medication orders may only be entered by practitioners with prescriptive authority.
- B. Orders upon admission must be appropriate to the patient's condition.
- C. All orders for medication shall include:
 - 1. Patient name, age and weight (or temporary estimation if necessary), medication, route of administration, dosage, frequency and date and time when recorded.
 - 2. Orders for vaccines, aerosols and other medications do not require route of administration or dosage where a standard dose and route of administration are implied by standard practice or by accepted protocol.
 - 3. If a current weight is not available at the time of order placement, orders for weight-based radiocontrast media may be placed with a dosage calculation (i.e. ml/kg) with the weight being confirmed and the exact dosage calculated by a staff member administering the radiocontrast media acting within the scope of the staff member's licensure.
 - 4. When appropriate, the duration of the course of therapy should be included in orders for medication. Indication of the dosage calculation, when based upon a weight, surface area, or age protocol is also required (e.g. mg/kg).
- D. In the interest of patient safety, verbal orders shall be limited to situations in which recorded orders are impractical, such as when the ordering practitioner is scrubbed for a procedure, when the patient's condition requires urgent intervention and it is impractical for the ordering practitioner to come to the patient care area in time to address the patient's care need or during the acute management of a life threatening emergency such that the benefits outweigh the risks of a verbally communicated order.
- E. Verbal orders may be given by the responsible attending physician, house staff, or appropriately certified advanced practice nurse, only to those individuals specifically determined by the attending physician to be appropriate to take such orders in their respective area of expertise. The order is to be entered into an approved portion of the medical record and authenticated by the individual to whom the order is dictated as "verbal - order by Dr. _____," giving the attending

physician's, house staff's or advanced practice nurse's name followed by the signature of the individual to whom the order was dictated and the time of the order. All verbal orders must be authenticated within forty-eight (48) hours. The individual accepting the verbal order shall read the complete order back to the ordering practitioner for verification.

- F. Under no circumstances is the above intended to permit any individual to initiate change, modify, or discontinue any clinical treatment or service without the expressed order to do so from the responsible attending physician, house staff, or advanced practice nurse.
- G. Verbal orders for DEA Schedule II Narcotics can only be for a single state dose.
- H. All written orders for treatment shall be legible and all orders, whether written or electronic, shall be complete, and authenticated by the responsible attending practitioner, house staff, or advanced practice nurse of the department to which the patient is assigned.
- I. The execution of all orders will be stopped upon transfer of service and/or transfer into or out of an intensive care unit. It is the responsibility of the receiving practitioner/service to review the computerized orders and electronically discontinue and/or write new orders as indicated. The receiving practitioner must enter an order stating that he/she is assuming care for the patient and responsibility for all active orders at that time.
- J. Unless specifically requested by the attending physician, consultants shall not enter orders on the patient, but shall record their recommendations on the consultation form. Exceptions to this rule apply to orders for preoperative and post-operative medications which are entered by the attending anesthesiologists and anesthesia house staff, pre and post procedure orders which are entered by the practitioner performing the procedure or appropriate qualified designee, and orders given in an emergency situation. Orders written by medical or dental students must be countersigned by a practitioner or house staff prior to implementation.
- K. Drugs and medications ordered for administration to patients should be selected, distributed and administered in accordance with the approved policies for the Pharmacy Department.
- L. When pre-printed patient orders are used, the responsible practitioner or house staff must sign the pre-printed form.
- M. Restraints are initiated and evaluated according to the Hospital's restraint policy.
- N. All orders must be signed or countersigned physically or electronically by the individual who created the orders or by the appropriate attending physician.

- O. Licensed professionals, acting within the scope of their practice, may implement physician orders pursuant to a written and/or electronic protocol that has been approved by the department and/or section chief(s) (after consultation with Legal Services) and is set forth in the policy/procedure manual for the department and/or section only for the following categories:
 - a. Over the counter medications.
 - b. Plain radiographs.
 - c. Basic screening, lab tests and basic screening tests.

5.4. Medical Records

A. Admitted Patients, Outpatient Surgeries and Imaging Studies:

1. The responsible attending physician shall be held accountable for the preparation of a complete medical record for each patient. This record shall include identification data; evidence of appropriate informed consent; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatments; pathological findings; progress notes; orders; final diagnosis; condition on discharge; final discharge summary; patient's home-going instructions regarding follow-up care; and autopsy when performed.
 - a. For medical patients, the responsible attending physician is the physician on service at the time of discharge.
 - b. For surgical patients, the responsible attending physician is the surgeon for the operation (as named on the operative report). If the patient does not undergo surgery, then the responsible attending physician is the admitting surgeon.
2. Medical records shall also contain documentation in accordance with the current standards of The Joint Commission (TJC).
3. The responsible attending physician shall authenticate the attestation sheet, history and physical examination, discharge summary, and, when appropriate, orders requiring counter signature and the operative report.
4. Upon admission, a history and physical examination and any updates thereto, shall be completed as set forth in Section 5.2(d) of the General Rules.

5. When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.
6. Pertinent progress notes shall be documented by attending physicians, house officers, advanced practice nurses or medical students (if counter-signed by the house officer or an attending physician). Progress notes shall be documented at least daily or as the patient's condition changes.
7. A brief procedure note must be entered into the electronic medical record at the end of the procedure. The procedure note should include:
 - (a) Date/time procedure completed;
 - (b) Procedure performed;
 - (c) Person performing procedure/assistant;
 - (d) Site marking performed (yes/no/not applicable);
 - (e) Time out performed (yes/no);
 - (f) Type of sedation, if applicable;
 - (g) Specimens obtained, if applicable, and;
 - (h) Complications, if any.
8. Medical records must be completed within thirty (30) days of discharge. A record shall be deemed complete at such time as all required dictations and/or written reports have been completed and authenticated. The responsible attending physician is required to complete medical records.
9. The attending physician is responsible for notifying in writing their respective department chief (or designated section chief) of their resignation thirty (30) days in advance of departure and copies made available to the Chief Medical Officer, Medical Staff Office and Health Information Management Department. The Health Information Management Department will assemble all medical records and make arrangements with the departing attending physician for completion of medical records. If the departing attending physician fails to follow the above notification process and fails to complete medical records prior to departure, it will be the responsibility of the department chief (or designated section chief) to complete the medical records on behalf of the departing practitioner. In the event a member of the Medical Staff is deceased, the department chief (or designated section chief) will assume the responsibility of medical record completion.
10. Entries in the progress notes may be made by a properly licensed health care professional who has input on the care of the patient in accordance with Hospital policies and procedures.

11. All clinical entries in the patient's record shall be dated, timed and their authors identified and co-signed as required.
12. Patients shall be discharged by order of the responsible attending physician, his/her house staff representative, or advanced practice nurse.
13. A discharge summary shall be composed on all patients categorized in patient classes Inpatient, Observation, and Outpatient in a bed. The discharge summary must be completed using the standard template provided in the electronic medical record. The discharge clinical summary shall contain:
 - (a) Statement of reasons for hospitalization;
 - (b) Impression on admission;
 - (c) Brief summary of hospital course;
 - (d) Final diagnosis;
 - (e) Operations and special procedures;
 - (f) Complications;
 - (g) Prognosis when indicated and condition on discharge;
 - (h) A review of discharge medications;
 - (i) Disposition of patient;
 - (j) Specific instructions given to patient and family regarding further care.
14. The discharge summary must be completed within forty-eight (48) hours of patient discharge by a member of the house staff, allied health professional, or attending physician. The responsible attending physician must authenticate the discharge summary within 30 days.
15. A death summary shall be composed on all patients who expire in the hospital. The death summary must be completed within forty-eight (48) hours of patient death by a member of the house staff, allied health professional, or attending physician. The responsible attending physician must authenticate the death summary within 30 days. The death summary must be completed using the standard template provided in the electronic medical record. The death summary shall contain:

- (a) Statement of reasons for hospitalization
 - (b) Impression on admission
 - (c) Brief summary of hospital course
 - (d) Final diagnoses
 - (e) Operations and special procedures
 - (f) Complications
16. For medical patients, the responsible attending physician is determined based on the attending note on the chart on day of discharge.
 17. For surgical patients, the attending surgeon for the case (as named on the operative report) will be responsible for the discharge summary.
 18. Medical record documentation must have a hand written or electronic signature. Use of signature stamps or rubber stamps is prohibited.
 19. No medical record shall be deemed complete until all deficiencies have been resolved. Incomplete medical records may be deemed complete when approved by the appropriate department and/or section chief(s).
 20. Attending physicians having incomplete records of one month or longer may be refused all clinical privileges, except to care for those patients who are in the Hospital at the time. Notification of incomplete medical records will be given to the attending physician's, applicable department and/or section chief(s), Medical Staff President and the Chief Medical Officer by the Director of Health Information Management.
 21. Written consent of the patient, if legally authorized, or his/her legal guardian is required for release of medical information to persons not otherwise authorized to receive this information.
 22. Access to medical records including x-rays of all patients, shall be afforded to members of the Medical Staff and their authorized designees and house staff for bona fide study and/or research consistent with institutional policies and preserving the confidentiality of personal information concerning individual patients. All such projects and authorized designees shall be approved by the chief of the appropriate department, and approved by the Institutional Review Board.

23. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. Practitioners who routinely transport medical records from one location to another are required to complete a Medical Record Transport Agreement. All records are the property of the Hospital and shall not otherwise be removed without permission of the Director of Health Information Management.
24. Written instructions given by a practitioner to a parent shall be documented in the patient's chart by the appropriate health care provider.
25. Rules regarding operative notes and records can be found in the "Rules for Operating Room" under Section 5.5. Rules and Regulations Manual.

B. For Ambulatory Patients

●Emergency Department Records:

1. An appropriate record shall be kept of each Emergency Department visit made by a patient and shall be incorporated into that patient's permanent Hospital record.
2. Each Emergency Department record should contain documentation of the following:
 - (a) Emergency care provided to the patient prior to arrival (if any);
 - (b) History, physical exam, final diagnosis, and treatment;
 - (c) Conclusions at the termination of treatment to include final disposition, condition at discharge and any instructions for follow-up care;
 - (d) Documentation must be completed by the end of the physician's shift. At a minimum, must include the independent practitioner's impression and plan of care, and;
 - (e) Emergency patient transfers to other organizations include reasons for transfer, stability of patient, acceptance by the attending physician at the receiving organization and responsibility during transfer.

●Clinic Records:

1. An accurate medical record shall be maintained for every patient receiving medical care provided by the ambulatory services.
2. For patients receiving continuing ambulatory care services, by the third visit, a medical summary list must contain the following:

- (a) Known significant medical diagnoses and conditions;
- (b) Known significant operative and invasive procedures;
- (c) Known adverse and allergic drug reactions;
- (d) Chronic medications known to be prescribed for and/or used by the patient.

C. Electronic Medical Records (EMR)

1. All practitioners who seek patient care activities at the time of initial Hospital appointment are required to complete training sessions on the use of the Hospital's EMR and provide appropriate documentation of successful completion of EMR training to Medical Staff Services prior to the initiation of any clinical activities.
2. All practitioners who provide ongoing patient care activities at NCH are required to utilize the EMR for computerized order entry and all applicable clinical documentation.
3. Non-compliance with these requirements can result in suspension of patient care activities, including elective admissions, outpatient care activities, and non-emergency surgical cases.
4. Enforcement of these requirements is the joint responsibility of the Medical Staff President and the Chief Medical Officer. Upon documentation that the practitioner has agreed to utilize the EMR for all applicable patient care activities, Hospital privileges will be reinstated.

5.5. Rules for Operating Room

- A. Except for life-threatening or limb-threatening emergencies, surgical procedures shall be performed only with the documentation of informed consent of the patient and/or his/her legal representative.
- B. The history and physical examination shall be completed prior to any surgery or procedure requiring anesthesia as set forth in Section 5.2(d) of the General Rules. The responsible practitioner shall document in the medical record the pre-operative diagnosis, and state the intended operation prior to the beginning of the procedure.
- C. If the patient is admitted from the operating room, the pre-operative history and physical may serve as the history and physical for the admission. This document will remain in the paper chart until discharged when it is scanned into the electronic record.
- D. When a completed history and physical is not available from the attending surgeon or other practitioner, the anesthesiologist may perform the history and physical in addition to the pre-anesthesia evaluation and shall complete the Anesthesia History and Assessment form accordingly. Regardless of who completes the history and physical examination, the attending surgeon must still examine the patient and document that the need for surgery is still present.
- E. Surgical procedures shall be performed only by a practitioner, with surgical privileges. When surgical procedures involve residents, the practitioner will be present for critical portions of the procedure.
- F. A resident at the appropriate level of training, as defined by the program director, may begin a surgical procedure in an emergent circumstance when delaying the start of the operation until the attending surgeon is present, could result in the loss of life or limb or the permanent impairment of a bodily system under the following circumstances:
 - 1. If the attending surgeon determines that the case is emergent and is not immediately available. The attending surgeon will directly inform the charge RN that the resident may begin the procedure and of the expected arrival time of an attending surgeon.
 - 2. If the attending surgeon cannot be contacted, the attending anesthesiologist may determine that the case is emergent and that the resident may begin the procedure. Each department/section will determine the level of training required for residents to start emergency cases and the residents will be responsible for knowing their limitation based on their level of training. The attending anesthesiologist will directly inform the charge RN that the resident may begin the procedure.

- G. Surgeons must be in the operating room and ready to commence surgery prior to the time scheduled in accordance with the operating room policies and procedures and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled. It will be the responsibility of the operating room to notify the surgeon if the actual starting time of the proposed case will be delayed more than fifteen minutes (15).
- H. Patients having symmetrical site surgery will have the correct surgical site identified and marked prior to any incision being made in accordance with applicable Hospital and operating room policies and procedures.
- I. A surgical timeout will occur prior to the surgical incision or start of procedure in accordance with applicable Hospital and operating room policies and procedures.
- J. All previous orders written for a patient are not effective while the patient is in the operating room but may be resumed postoperatively. The resident, APN, or attending physician are responsible for reviewing and resuming suspended orders postoperatively.
- K. Anesthesia personnel shall maintain a complete anesthesia record as described in the policies and procedures of the Department of Anesthesiology.
- L. All tissue specimens removed during a surgical procedure will be sent to the Hospital pathologist except those specimens that may be exempt from this requirement under the policies of the operating room. The Hospital pathologist will make such examinations as he/she may consider necessary to arrive at a pathological diagnosis.

In consultation with the surgical pathologist on duty, the surgeon and the pathologist may agree that certain specimens do not require pathologic examinations. A listing of specimens automatically exempted from examination shall be mutually agreed upon and every three years (3) reviewed and updated by the Section Chief of Anatomic Pathology and the Surgeon-in-Chief. The pathologist shall sign his/her report on examined specimens.

When specimens are removed for special laboratory procedures other than histopathology, the studies and their results will be recorded with the Department of Laboratory Medicine. The Hospital pathologist shall be notified prior to removal of the specimens when the study includes gross anatomic evaluation of a portion of the specimen. The practitioner primarily responsible for the patient's care will determine the priorities for use of the specimen removed.

- M. Operative reports are to be dictated and recorded in the medical record immediately after surgery and contain the preoperative diagnosis, a description of the operative findings, the technical procedures, the specimen(s) removed (if any), the postoperative diagnosis, estimated blood loss, any complications and the name of the primary surgeon and any assistants. In the case of cardiothoracic surgery when estimated blood loss cannot be accurately estimated, "N/A" may be entered for estimated blood loss.
- N. An operative note is required for any surgical procedure performed on a patient.
- O. Operative notes may be dictated through Medquist or entered directly into Epic using the procedure note type. Those notes dictated through Medquist must be authenticated within the Streamline Health.
- P. The Surgeon-in-Chief shall immediately suspend the surgical scheduling of any surgeon who has not dictated or otherwise not submitted operative notes or attending staff notes outstanding over three (3) days. The suspension will be in effect until the operative notes or attending staff notes are completed. In the event that an emergency surgical case arises during the period that the surgeon's scheduling is suspended, the suspension will be waived for the care of that particular emergency case.
- Q. When a surgeon wishes to use an operating room previously scheduled by another staff member, it shall be the responsibility of that surgeon to personally contact the staff member who originally scheduled the room and secure permission for this change. Exceptions will be made only in cases of life-threatening or limb-threatening emergencies.
- R. Operative procedures shall be scheduled in conformance with the delineation of privileges granted the individual surgeon.
- S. Scheduling policies, rules and changes thereof for the operating room shall be reviewed and approved by the Perioperative Council. All approved rules and regulations of the operating room shall be available in the operating room supervisor's office.
- T. All operative procedures performed in the operating room will be under the supervision of the Surgeon-in-Chief.

5.6. Rules for Dental Care

A patient admitted for dental care shall receive the same appraisal as patients admitted for medical services. Both the dentist and an attending physician have areas of responsibility.

- A. The dentist is responsible for that part of the history and physical examination which is related to dentistry. The pre-operative diagnosis should be supported by radiographs when appropriate.
- B. The practitioner is responsible for the performance of an admission history and physical examination. This examination will be performed in accordance with Section 5.2(d) of the General Rules.
- C. A practitioner is responsible for the management of any medical problem that may be present, or that may arise during the hospitalization of the dental patient.

5.7. Rules for Podiatric Care

A patient admitted for podiatric care shall receive the same appraisal as patients admitted for medical services. Both the podiatrist and an attending physician have areas of responsibility.

- A. The podiatrist is responsible for that part of the history and physical examination which is related to podiatry. The pre-operative diagnosis should be supported by radiographs when appropriate.
- B. The practitioner is responsible for the performance of an admission history and physical examination. This examination will be performed in accordance with Section 5.2(d) of the General Rules.
- C. The practitioner is responsible for the management of any medical problem that may be present, or that may arise during the hospitalization of the podiatric patient.

5.8. Rules for Emergency Department Care

- A. The Nationwide Children's Hospital shall maintain an Emergency Department with medical and dental care available twenty-four (24) hours a day. The responsibility for medical or dental care shall be given only to licensed physicians or dentists who are either members of the Nationwide Children's Hospital Medical Staff, house staff or credentialed by the Medical Staff Office.
- B. The duties and responsibilities of all personnel serving patients within the Emergency Department shall be defined in a policy and procedure manual which will be readily available in the Emergency Department area.
- C. The policies and procedures of the Emergency Department should be developed and recommended by the Section chief of Emergency Medicine, Nurse Director, and the Administrator for Ambulatory Services and approved by the Chief Medical Officer and the Medical Executive Committee. All Emergency Department policies impacting patient care or affecting medical practice shall be sent to the Medical Executive Committee for approval.
- D. An appropriate medical record shall be kept for every patient receiving Emergency Department service, and shall be incorporated into that patient's permanent inpatient record if one exists. Other Emergency Department records should be kept on file either in original form or on microfilm. The Emergency Department record should contain complete patient identification, medical information, diagnosis and disposition as defined in the Medical Records Section, of the Medical Staff Rules and Regulations.
- E. Each patient's medical record shall be authenticated by the licensed practitioner in attendance who is responsible for its clinical accuracy.
- F. Emergency Department records shall be reviewed regularly by those responsible for the operation of the Emergency Department and by the Medical Records Department. Records requiring further review of medical judgments and those records on patients dying within the first twenty-four (24) hours who have been received through the Emergency Department shall be regularly reviewed by the Section Chief of Emergency Medicine.
- G. The primary care physician, subspecialist or dentist, if able to be determined under the circumstances, will be contacted if he/she is a member of the Medical Staff, referred the patient to the Emergency Department, if follow-up care needs to be arranged, or if the patient is admitted to the Hospital.
- H. Consultations in the Emergency Department may be provided to patients on request of the Emergency Department staff, by physician or dentist representatives of the specialty services, either members of the house staff or of the attending Medical Staff.

- I. If a consult was completed in the Emergency Department immediately prior to admission, that consult note may serve as the admission history and physical, but the user must still enter a reference note in the history and physical section as a placeholder.

5.9. Rules for Reporting and Review of Practices of HBeAg-Positive or HIV Antibody

- A. The State Medical Board of Ohio has mandated that practitioners who perform invasive procedures and who are HBeAg-positive or HIV antibody positive must report their infection status to an appropriate review board. Reporting is required in an effort to ensure the safety of patients and other health care workers.
- B. The review board could be the Ohio Department of Health or institution-based (Nationwide Children's Hospital Medical Staff).
- C. The purpose of the review board is to review the health status of HBeAg-positive or HIV antibody positive practitioners and to determine whether there are any procedures or practices of the infected practitioners that should be prohibited or modified due to the likelihood of placing patients or other health care workers at risk of acquiring either Hepatitis B or HIV from the infected practitioners.
- D. The Medical Staff President of Nationwide Children's Hospital will establish a review board whose functions will include the following:
 - 1. Maintain an up-to-date knowledge of procedures or practices considered to be at risk for transmission of Hepatitis B or HIV (exposure prone procedures).
 - 2. Receive reports of HBeAg-positive or HIV antibody practitioners on the Nationwide Children's Hospital Medical Staff from either the infected practitioners or other Medical Staff members.
 - 3. Review the procedures and practices of HBeAg-positive or HIV antibody positive practitioners.
 - 4. Determine if any procedures or practices of the HBeAg-positive or HIV antibody positive practitioners should be prohibited or modified.
 - 5. Monitor HBeAg-positive or HIV antibody positive practitioners' procedures and practices to ensure compliance with review board recommendations.
 - 6. The Medical Staff Office will maintain all information and review materials in the respective practitioner's credential file. All practitioner credential files will be maintained in a confidential and non-discoverable manner pursuant to Ohio Revised Code (2305.25; 2305.251; 2305.252).
- E. The Nationwide Children's Hospital Medical Staff review board will be known as "Infection Review Board".

- F. The Review Board will consist of five members of the Medical Staff who are knowledgeable concerning:
1. Transmission of hepatitis B and HIV
 2. Extent of risk for transmission of hepatitis B or HIV by invasive procedures
- G. These individuals will include:
1. Surgeon-in-Chief or designee
 2. Practitioner-in-Chief or designee
 3. Practitioner Director of Department of Epidemiology or designee (chair)
 4. Department Chief of Dentistry or designee
 5. Practitioner from Critical Care Section or designee
- H. Medical Staff members who perform invasive procedures and who are at risk for hepatitis B or HIV infection must know their infection status (ignorance of infection status is not an acceptable alternative to self-reporting).
- I. Medical Staff members who perform invasive procedures and who are HBeAg-positive or HIV antibody positive must report their infection status to the "Infection Review Board" or to the Ohio Department of Health.
- J. A Medical Staff member who is aware that another Medical Staff member is HBeAg-positive or HIV antibody positive and performs invasive procedures must do the following:
1. Notify the HBeAg-positive or HIV antibody positive practitioner of his/her duty to report his/her infection status to the "Infection Review Board".
 2. Notify the "Infection Review Board" of the infection status of a HBeAg-positive or HIV antibody positive Medical Staff member if:
 - (a) The Medical Staff member is certain of the infection status of the other Medical Staff member, and
 - (b) There is sufficient reason to believe that the Medical Staff member has not self-reported his/her infection status to the "Infection Review Board".
- K. A HBeAg-positive or HIV antibody positive Medical Staff member will be expected to comply with the recommendations of the "Infection Review Board".

- L. A HBeAg-positive or HIV antibody positive Medical Staff member who disagrees with recommendations of the “Infection Review Board” or who feels that the “Infection Review Board” has not provided fair recommendations may appeal for an additional review by the Chief Medical Officer.
- M. A HBeAg-positive or HIV antibody positive Medical Staff member who disagrees with the resolution of his/her appeal to the Chief Medical Officer may appeal for an additional review by the Ohio Department of Health.
- N. The “Infection Review Board” will be notified of the outcome of appeals to the Chief Medical Officer and/or the Ohio Department of Health. The monitoring of the procedures and practices of the HBeAg-positive or HIV antibody Medical Staff member by the “Infection Review Board” will be consistent with the recommendations of either the Chief Medical Officer or the Ohio Department of Health.
- O. HBeAg-positive or HIV antibody positive Medical Staff members who do not comply with recommendations of the “Infection Review Board” (or the Chief Medical Officer or Ohio Department of Health in cases of appeals) will be managed according to Bylaws Manual Article 1.10.

5.10. Guidelines for Written Informed Consent

The Medical Staff shall provide practitioner services to the patient on a consent basis, which shall include obtaining written informed consent from the appropriate authorized individual, in accordance with these Guidelines.

A. Applicable Procedures

1. Written informed consent from the patient/parent/legal guardian must be obtained for:
 - (a) All investigational studies and clinical trials in accordance with federal guidelines for the protection of research subjects;
 - (b) All patients admitted to the surgical suite;
 - (c) All procedures requiring conscious sedation or general anesthesia anywhere in the Hospital;
 - (d) All surgical procedures that remove tissue; and
 - (e) Infusion of blood or blood products.

B. Required Elements of the Written Informed Consent

1. Informed consent includes information that permits the patient/parent/legal guardian to make an informed decision and shall include the following elements:
 - (a) The nature and purpose of the procedure;
 - (b) What the procedure is expected to accomplish;
 - (c) The names of practitioners performing the procedure, except in emergency situations;
 - (d) The reasonably known risks of the procedures;
 - (e) The alternatives for treatments; and
 - (f) Disposition of any tissue or specimens obtained.

C. Exceptions to Obtaining Written Informed Consent

1. Verbal Informed Consent – When written informed consent is not practical, verbal informed consent for procedures or therapies may be obtained by telephone from a parent or legal guardian if the required elements stated above are covered. The consent conversation should be witnessed by another healthcare provider. Evidence of this verbal consent must be documented in the patient's medical record and signed by the person obtaining consent and the witness to the consent.
2. Consent Unavailable - When it is not possible to obtain consent to authorize treatment of a patient and, in the sole opinion of the practitioner, treatment is necessary to save the patient's life, or prevent permanent physical or mental impairment, and such treatment is given, then the practitioner shall write and sign a statement in the patient's medical record explaining the reasons that care must be initiated without authorized consent and include documentation of the attempts to contact the individual authorized to give consent.
3. Some invasive procedures are part of standard care for specific diagnoses and therapies (e.g. peripheral intravenous or arterial punctures, lumbar punctures, etc.) In those cases, written informed consent is not strictly required and left to the discretion of the practitioner.

D. Acceptable Methods of Documentation

1. Informed consent for blood/blood product administration shall be documented on the Blood/Blood Product Transfusion Consent Form.
2. All other informed consent shall be documented by completion of Form AM-20 "Agreement to and Consent for Surgery, Sedation, Anesthesia or Special Procedures" or by documenting the information in the progress note of the patient's medical record.

E. Expiration of Written Informed Consent

1. A new informed consent must be obtained whenever the facts covered by the previous consent have changed. In the absence of changed facts, when the previous informed consent is more than sixty (60) days old, it must be reviewed by the practitioner with the parents/legal guardian/patient.
2. Notwithstanding the foregoing, given the nature of transplant procedures, the consent form for organ transplantation is valid for one (1) year. The information in the transplant consent form, however, should be reviewed with the consenting party periodically. A new transplant informed consent is required whenever the facts covered by the previous consent have changed.

5.11. Qualified Medical Personnel to Perform Medical Screening for Emergency Medical Conditions

- A. Nationwide Children's Hospital Medical staff and allied health professionals shall comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).
- B. Pursuant to EMTALA, physicians must perform the required medical screening unless the organization approves other Qualified Medical Personnel to perform such medical screenings. At Nationwide Children's Hospital, including all off-site urgent care locations, Qualified Medical Personnel shall include Advanced Practice Nurses and Registered Nurses who may perform the medical screening required by EMTALA pursuant to a written protocol and other written agreements, that have been approved by the section/department chief(s), nurse manager for the area, the Chief Nursing Officer and the Chief Medical Officer.