# RULES, REGULATIONS AND POLICIES MANUAL OF THE MEDICAL STAFF
## FAIRFIELD MEDICAL CENTER
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PART ONE

DEFINITIONS

1.1 INCORPORATION OF DEFINITIONS

The Rules, Regulations and Policies Manual adopts and incorporates by reference the definitions contained in the Medical Staff Bylaws of the Medical Center.
PART TWO

ADMISSION AND DISCHARGE

2.1 TYPES OF PATIENTS

The Medical Center shall accept patients for care and treatment within the capabilities of the Medical Center. The MEC or other Medical Center committee may establish procedures for handling certain diseases. All patients are admitted without regard to race, creed, color, handicap, sex, sexual orientation, national origin, or source of payment. Admission is contingent upon adequate facilities and personnel being available to care for the patient.

2.2 ADMITTING PREROGATIVES

A patient may be admitted to the Medical Center only by an Appointee of the Medical Staff. All Practitioners shall be governed by the official admitting policies of the Medical Center. No patient shall be admitted until a provisional diagnosis has been stated.

2.3 RESPONSIBILITY

An Appointee of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Medical Center, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff Appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the inpatient medical record. Appointees with prearranged routine practice coverage shall notify the Director of Nursing and the Medical Staff Office of such coverage. The Medical Staff Office shall publish a schedule of such coverage, the recipients of which shall include the chief of the department in which the coverage shall occur, the Medical Center operator and the Department of Emergency Medicine.

2.4 ADMISSIONS OF PATIENTS IN EMERGENCY CONDITIONS

2.4-1 BED AVAILABILITY

In any case in which it appears the patient will have to be admitted to the Medical Center, the Practitioner shall contact the admitting office to ascertain whether there is an available bed.

2.4-2 JUSTIFICATION OF EMERGENCY ADMISSION

Practitioners admitting emergency cases shall be prepared to justify to the MEC and the administration of the Medical Center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly
justify the patient being admitted on an emergency basis and these findings must be recorded on the patient’s chart as soon as possible after admission.

2.4-3 ASSIGNMENT OF APPOINTEES

A patient whose condition requires admission on an emergency basis, but who does not have a private Practitioner, will be assigned to the care of the Appointee of the Active Medical Staff who is on call for the appropriate department and specialty for such admissions. The department chief shall be responsible for providing a schedule for such arrangements, including exemption for good cause.

2.5 OUTPATIENT OBSERVATION

Outpatient observation services may be utilized in accordance with official Fairfield Medical Center Policies to evaluate an outpatient’s condition or to determine the need for a possible admission. This is not to be used in place of a medically appropriate inpatient admission.

2.6 PATIENT CARE COVERAGE

Each Practitioner must assure timely, adequate professional care for his/her patients in the Medical Center. A Practitioner who will not be available within a reasonable period of time shall, on the order sheet of the chart of each of his/her patients, indicate in writing the name of a Practitioner, who must be an Appointee of the Medical Staff, with similar Clinical Privileges and with whom prior arrangements have been made to assume responsibility for the care of the patient during his/her absence. For shorter periods of time, the nursing supervisor on duty shall be informed of such arrangements. Written standing orders indicating alternate coverage arrangements may be filed with the nursing service to fulfill these requirements.

“Reasonable period of time” and “similar Clinical Privileges” will be defined by the Medical Executive Committee with input from the individual departments, subject to approval of the Board.

2.6-1 TIME FRAMES FOR SEEING PATIENTS

Patients must be seen by an attending physician or his/her designee as clinically indicated and in accordance with geographic proximity requirements for their specialty not to exceed twenty four (24) hours from inpatient admission for standard care and not to exceed twelve (12) hours from inpatient admission to special care units and daily thereafter until discharge. Designee is defined as a covering practitioner or another practitioner who agrees to cover the patient.
2.6-2 PATIENTS SEEN BY ALLIED HEALTH PRACTITIONER
Patients must be seen by a supervising or collaborating physician as clinically indicated, but not to exceed twenty four (24) hours from inpatient admission for standard care and not to exceed twelve (12) hours from inpatient admission to special care units and daily thereafter until discharge.

2.7 CATEGORIES OF MEDICAL CONDITIONS
The Medical Staff, when necessary, shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the MEC. When necessary, admission of patients shall be prioritized on the basis of the severity of their condition.

2.8 ADMISSION TO INTENSIVE CARE UNIT
The Critical Care Committee of the Medical Staff shall be responsible for activity of the Medical Staff in operation of the Intensive Care Unit (“ICU”) and reports to the MEC.

2.9 ADMISSION TO THE PSYCHIATRIC UNIT
Patients may be admitted to the Psychiatric Unit by any Psychiatrist with admitting Clinical Privileges on the Medical Staff of the Medical Center. Admissions must meet the criteria established for the Psychiatric Unit and be approved by the Medical Director of the Psychiatric Unit or his/her designee.

2.10 DISCHARGE
An inpatient shall be discharged only on a written order of the attending Practitioner. Should a patient leave the facility against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. The patient should be asked to sign a release of responsibility for the Medical Center, Medical Center employees and the Practitioners.

2.11 DEATH OF PATIENT
2.11-1 PRONOUNCEMENT
In the event of the death of a patient within the Medical Center, the deceased shall be pronounced dead within a reasonable time by the attending Physician, or his/her designee. Nursing personnel may recite the facts of the deceased's present medical condition to the attending Physician (M.D./D.O.) for the pronouncement of death.
2.11-2 AUTOPSY

It shall be the duty of all Medical Staff Appointees to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed by the Medical Center Pathologist or by a Practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within sixty (60) days.

Autopsies shall be considered or performed in accordance with the Medical Center policy “Autopsy Guidelines.”

The attending Practitioner of a patient on whom an autopsy is to be performed, for any reason, shall be notified of the autopsy by the Medical Center Pathologist or his/her designee.

2.11-3 ORGAN DONATION

The Medical Staff shall follow the applicable Medical Center policies on organ, tissue and eye donation/procurement and shall follow the applicable laws for organ, tissue and donation/procurement.
PART THREE
MEDICAL RECORDS

3.1 PREPARATION AND CONTENT

3.1-1 RESPONSIBILITY

The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. All Practitioners are expected to utilize the Electronic Health Record (EHR). This includes order entry, medication reconciliation, documentation and other available functionalities. Use of the EHR is considered part of the routine practice of medicine at the Medical Center and, as such, is a responsibility of maintaining Medical Staff Membership and/or Clinical Privileges.

3.1-2 CONTENT

The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among healthcare providers. This shall include:

(a) The patient’s name, address, date of birth and the name of any legally authorized representative;

(b) The patient’s legal status, for patients receiving mental health services;

(c) Emergency care provided to the patient prior to arrival, if any;

(d) The record and findings of the patient's assessment;

(e) A statement of the conclusions or impressions drawn from the medical history and physical examination;

(f) The diagnosis or diagnostic impression;

(g) The reason(s) for admission or treatment;

(h) The goals of treatment and the treatment plan;

(i) Evidence of known advance directives;

(j) Evidence of informed consent for procedures and treatments for which informed consent is required;
(k) Diagnostic and therapeutic orders, if any;

(l) All diagnostic and therapeutic procedures and tests performed and the results;

(m) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;

(n) Progress notes made by the Medical Staff and other authorized individuals;

(o) All reassessments, when necessary;

(p) Clinical observations;

(q) The response to the care provided;

(r) Consultation reports;

(s) Every medication ordered or prescribed for an inpatient;

(t) Every dose of medication administered and any adverse drug reaction;

(u) Every medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;

(v) All relevant diagnoses established during the course of care;

(w) Any referrals and communications made to external or internal care providers and to community agencies;

(x) Any additional requirements imposed under federal or state regulations.

(y) Conclusions at termination of hospitalization;

(z) Discharge instructions to the patient and, when appropriate, family; and

(aa) Clinical resumes and discharge summaries, or a final progress note or transfer summary.

3.2 HISTORY AND PHYSICAL

3.2-1 COMPLETION/RECORDING

A complete admission history and physical examination shall be completed by the responsible Practitioner and recorded within twenty-four (24) hours of admission for inpatient admissions. This report should include all pertinent findings
resulting from an assessment of all the systems of the body. See section 3.6 of this manual for history and physicals of obstetrical patients.

If an H&P has been performed and documented within thirty (30) days of the patient’s inpatient or outpatient admission or registration to the hospital or admission or registration for a scheduled operative or invasive procedure requiring anesthesia services, a legible copy of that H&P examination may be used in the patient's medical record, provided an update is performed by a licensed independent practitioner or designee with privileges to perform H&P’s, and it is documented prior to the procedure. Non-surgical patients must have H&P’s documented at the time of admission or registration or 24 hours thereafter.

This updated H&P examination must:

(a) Address the patient’s current status/any changes in the patient’s status (if there are no changes in the patient’s status, this should be specifically noted)

(b) Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior H&P, or to address any areas where more current data is needed

(c) Confirm that the necessity for the admission, procedure, or care is still present

(d) Be written or otherwise recorded on, or attached to, the previous H&P, or written in a progress or consult note

(e) Be placed in the patient’s medical record prior to surgery or a procedure requiring anesthesia services.

A history and physical may be accepted from a Practitioner not on the Medical Staff of the Medical Center provided that the history and physical is reviewed, revised, and updated upon admission and as otherwise necessary to reflect any changes in the patient’s current condition and it must be countersigned by the attending Practitioner at the time of admission.

To be acceptable, outside medical records should be in a form compatible with the current medical records system.

The attending Practitioner or surgeon may use if he/she desires, the Fairfield Medical Center “Minor History” form for patients admitted in the Medical Center for forty-eight (48) hours or less.

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled.
unless the attending Practitioner states in writing that such delay would be
detrimental to the patient.

The attending Practitioner shall countersign the history, physical examination,
preoperative note, and operative or procedure note when they have been recorded
by any person other than an Appointee of the Medical Staff.

3.2-2 HISTORY

The medical history will include at least the following:

(a) Chief complaint;
(b) Details of the present illness or care needs;
(c) Relevant past history; and
(d) Relevant inventory by body systems.

3.3 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit
continuity of care and transfer ability. Whenever possible each of the patient’s clinical
problems should be clearly identified in the progress notes and correlated with specific
orders as well as results of tests and treatment. Progress notes shall be written daily by the
attending Physician or by a Practitioner designated by the attending Physician and at the
direction of the attending Physician.

3.4 OPERATIVE REPORTS

Operative reports shall include patient name, patient medical record number, date and time
of surgical procedure(s) performed, preoperative diagnosis, postoperative diagnosis,
procedure(s) performed, name(s) of surgeon(s), name(s) of assistant(s), type of anesthesia
administered, specimen(s) removed, description of surgical techniques and findings, and
estimated blood loss. Operative reports shall be written immediately and dictated following
invasive procedures for outpatients as well as inpatients and the report promptly signed by
the Practitioner and made a part of the patient’s current medical record. If the operative
report is not immediately placed in a medical record after surgery, a progress note must be
entered immediately. Immediately is defined as upon completion of surgery and before the
patient is transferred to the next level of care. This is to ensure that pertinent information is
available to the next caregiver. The entering of a progress note does not relieve the
Practitioner from the requirements of otherwise writing, dictating or signing operative
reports in accordance with this section.

Any Practitioner with operative reports not dictated within forty-eight (48) hours following
the day of the operation shall receive a warning, and any Practitioner with delinquent
operative reports seventy-two (72) hours following the day of the operation shall automatically be denied operating Clinical Privileges until his/her operative reports are current. The Medical Records Department will notify the department chief of violations to this rule.

3.5 CONSULTATION REPORTS

Consultation is obtained when additional expertise is required beyond the skill and competence of the attending physician. Circumstances may include but not be limited to the patient’s response to treatment or if further information is needed for diagnosis. Consultations shall show evidence of a review of the patient’s medical record by the consultant, pertinent findings on examination of the patient, and the consultant’s opinion and recommendations. This report shall be made a part of the patient’s medical record. A statement such as “I concur” does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

3.6 PRENATAL RECORDS

The current obstetrical medical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Practitioner’s office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. The prenatal record may be used as the History and Physical if updated within thirty (30) days prior to admission; if updated more than seven (7) days prior to admission, an interval note must be made. For cesarean section patients, the interval note must be made prior to surgery, except when not possible for an emergency. If the patient did not have prenatal care or the patient’s prenatal record is not available, a complete history and physical must be charted within twenty-four (24) hours of admission and prior to any surgical procedure.

3.7 DATE, SIGNATURE AND ABBREVIATIONS

All clinical entries, including verbal orders, in the patient’s medical record shall be legible, complete, dated, timed, and authenticated by the person making the entry.

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations shall be kept on file in Medical Records.

3.8 DISCHARGE SUMMARY

The Medical Center discharge summary is part of the patient’s medical record and shall include (i) the reason for hospitalization, (ii) the procedures performed, (iii) the care, treatment, and services provided, (iv) the patient’s condition and disposition at discharge, (v)
information provided to the patient and family, and (vi) provisions for follow-up care. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations. A discharge summary shall be written or dictated on medical records of all inpatient and observation patients. A discharge summary is always required, regardless of the length of stay, for all deaths, transfers to other acute-care facilities, or for any patient with major, and/or multiple organ involvement. (This includes lengths of stay under forty-eight (48) hours). For observations, normal newborns, uncomplicated deliveries, or for patients hospitalized for less than forty-eight (48) hours with problems of only a minor nature (minor or single organ involvement), a discharge progress note may substitute for the discharge summary provided that the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. The progress note may be written or dictated.

When specific instructions given to the patient and/or family are not included in the discharge summary documentation, the Continuity of Care Orders / Discharge Instructions form or other pre-printed instructions are recognized as a part of the discharge summary and the patient’s medical record.

When pre-printed instructions are given to the patient or family, the record so indicates and a sample of the instruction sheet in use at the time is on file in the Medical Records Department.

When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

3.9 AUTHENTICATION

Authentication of documents in the medical record, including all orders and documentation generated from the physician’s office, will be accomplished using electronic signature. Written signatures will be authorized for only those documents that electronic signature capabilities are not available. The Practitioner must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document. The use of rubber stamps is not permitted. All electronic signatures will be accompanied by an electronically generated date/time and signature statement with the author’s credentials. An electronic signature is defined as:

a) A code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as the individual’s electronic signature;

b) A computer-generated signature code created for an individual;

c) An electronic image of an individual’s handwritten signature created by using a pen computer.
3.10 COMPLETION OF THE MEDICAL RECORD

The patient’s medical record shall be complete at time of discharge, including progress notes, final diagnosis and dictated discharge summary. After compilation of all reports by Medical Records, the discharge summary and all other entries must be completed by the Practitioner within thirty (30) days.

The Practitioner is personally responsible to complete all records within thirty (30) days. Incomplete Record Status is continuously provided in real-time to the Practitioner via the Physician Portal. Failure on the part of the Practitioner to complete all records within thirty (30) days will result in all Practitioner Privileges being suspended until all records (greater than 30 days) are completed.

A medical record is ordinarily considered complete when the required contents, including any required clinical resume or final progress note is assembled and signed and when all final diagnoses and any complications are recorded without use of symbols or abbreviations.

Practitioners have the option to request a waiver of these requirements for planned vacations or professional absences. Requests for a waiver must be made with the President of the Medical Staff. In no case will the delinquency process be enacted due to delays in the Medical Information Services Department. Enactment of the suspension process shall not give rise to any of the hearing or appeal rights set forth in the Medical Staff Bylaws and are not reportable to the National Practitioner Data Bank or the State of Ohio Medical Board.

3.11 FILING

A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed incomplete by the Chief Medical Officer.

3.12 ACCESS TO MEDICAL RECORDS

3.12-1 BY PATIENT

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

3.12-2 TO APPOINTEES

Free access to all medical records of all patients shall be afforded to Appointees of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee and any applicable IRB before records can be studied. Absent an authorization for release from the patient, requests by former Appointees of the Medical Staff for access to information from the medical records of their patients shall be reviewed by legal counsel. Access should not be denied to Appointees participating in certain business functions in which access to medical records is necessary, included but not limited to Medical Staff officers and Quality Improvement Committee
functions, may also have access to medical records in accordance with Medical Center policies and current laws regarding medical confidentiality.

3.13 OWNERSHIP AND REMOVAL OF MEDICAL RECORDS

All medical records are the property of the Medical Center and shall not otherwise be taken away without permission of the Medical Center President. Medical records may be removed from the Medical Center’s jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous medical records shall be available for the use of the attending Practitioner. This shall apply whether the patient is attended by the same Practitioner or by another. Unauthorized removal of medical records from the Medical Center is grounds for suspension of the Practitioner for a period to be recommended by the MEC of the Medical Staff.

3.14 CORRECTIONS OF MEDICAL RECORDS

3.14-1 PURPOSE

To provide an acceptable method of correcting entries in the medical record.

3.14-2 POLICY

The Medical Center recognizes the need to protect the integrity of the medical record, therefore:

(a) All corrections should be made by the author of the entry;
(b) Never erase or obliterate in any manner of the entry that is incorrect. Do not attempt to improve legibility;
(c) Using ink, draw a single line through (but do not obliterate) the incorrect entry and write the word “error” adjacent to it. Indicate the correction, or reference where the correction was recorded, sign and date it;
(d) In cases where changes require additional space, a written/transcribed addendum may be added giving the correct information and the reason for the change. The addendum should be signed, dated (current date) by the person making the correction.
(e) Dictated reports are considered final once they have been authenticated. Once signed, they may not be removed from the medical record. An addendum can be made to the report and added to the medical record or an error (i.e., misspelled word) may be corrected following the accepted method outlined above. If the Practitioner that dictated the report determines that an entirely new report should be dictated to replace the original report, then the original report shall be annotated as follows: “VOID - SEE AMENDED REPORT DATED.” The corrected report should be annotated as follows, “CORRECTED REPORT TO THAT DICTATED ON _______.”
PART FOUR
GENERAL CONDUCT OF CARE

4.1 TREATMENT CONSENT

A general treatment consent form, signed by or on behalf of every patient admitted to the Medical Center, must be obtained at the time of admission. The admitting office should notify the attending Practitioner whenever such consent has not been obtained and the admitting office shall obtain this consent as soon as possible.

It is the sole responsibility of the Practitioner who intends to perform a medical procedure for which informed consent is required to obtain written consent. The informed consent must be in writing and:

(a) Set forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, alternatives, and treatment options, and, except in emergency situations, sets forth the names of the Practitioners who shall perform the intended procedures;

(b) Demonstrate that the person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner; and

(c) Be signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

The informed consent shall be obtained prior to the induction of anesthesia or mind altering drug. If a patient cannot give the consent himself or herself, or if the situation is an emergency and no consent can be obtained at all, the reasons for this should be fully explained on the patient’s medical record. A consultation in such cases should be undertaken if time permits. Should a second operation be required during the patient's stay in the Medical Center, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they all may be described and consented to on the same form. This consent form shall be approved by the clinical department and the MEC.
4.2 ORDERS

4.2-1 GENERALLY

All providers placing orders on patient care areas with Computerized Patient Order Entry (CPOE) system access will enter the orders into the CPOE system.

Orders may be placed in CPOE remotely by providers using facility-approved remote order authentication. Providers will not share their order authentication methods or devices with any unapproved providers. Remotely-placed, STAT or urgent orders will be communicated immediately to the appropriate staff caring for the patient.

All written orders for treatment will be in blue or black ink, dated, timed, and signed by the responsible Practitioner.

Facsimile copies are regarded as original written orders according to Medical Center administrative policy.

4.2-2 VERBAL/TELEPHONE ORDERS

Any Practitioner responsible for care of the patient, including the Practitioner covering for the ordering Practitioner, may sign any verbal or telephone orders for that patient.

The order must be dated, timed and authenticated promptly by the ordering Practitioner or another Practitioner who is responsible for the care of the patient. The order must be authenticated no later than thirty days after the date of the patient’s discharge.

A verbal or telephone order should be used infrequently and only when necessary, but shall be considered to be in writing if dictated to authorized personnel who transcribe orders as indicated in below.

Medical Center personnel are authorized to accept orders verbally or by telephone from Practitioners with Medical Staff Clinical Privileges or their authorized personnel and enter the orders into the CPOE system. Each order will be immediately read back to the ordering Practitioner and immediately confirmed or corrected by the ordering Practitioner. Outpatient orders can be accepted from any licensed Practitioner in accordance with Medical Center departmental policies. Such dictated orders will be documented on approved forms in the patient’s medical record according to Medical Center administrative policy. Individuals authorized to accept and transcribe orders for Practitioners include the following:

(a) Any order may be accepted by registered nurses, licensed practical nurses, and physician assistants;
(b) Any order except orders for medications, “No Code”, or “Do Not Resuscitate (DNR)” status may be accepted by department/unit clerks or secretaries, central scheduling, and registration personnel; to the extent that such an order is a treatment order it will be relayed to a registered nurse or appropriate Practitioner;

(c) Only orders pertinent to their medical/ancillary service may be accepted by the following personnel:

(i) Case Management personnel;

(ii) Dietitians;

(iii) Imaging personnel;

(iv) Laboratory personnel;

(v) Pharmacist;

(vi) Rehabilitative Services personnel;

(vii) Echocardiographers; or

(viii) Respiratory Therapy personnel

4.2-3 DIAGNOSTIC ORDERS

Orders for diagnostic procedures such as laboratory, imaging, and other procedures must include diagnostic or other medical information, which addresses the reason or medical necessity of each individual test. Such diagnostic information must be documented in the Practitioner’s order. The Medical Staff authorizes those Practitioners who are not Medical Staff members to be able to order non-invasive laboratory and radiologic tests per hospital protocol.

4.2-4 ORDERS FOR RECURRING TESTING/TREATMENT

Orders for recurring testing or treatment must include the frequency interval and require both a starting and an ending date. Recurring orders cannot be made for a period of time longer than one year. All recurring orders will be discontinued after one year. Discontinued orders shall require a new written order if continued testing or treatment is necessary. Any changes in the original order (such as changes in frequency or the patient’s diagnosis) require a new written order.
4.2-5 LEGIBILITY OF ORDERS

The Practitioner’s orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or clarified by the Practitioner.

4.2-6 ROUTINE ORDERS

Prior to implementation, a Practitioner’s routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient’s medical record, dated and signed by the Practitioner. Nothing in this Section shall preclude a Practitioner from appropriately issuing verbal orders in accordance with Section 4.2-2.

4.2-7 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are canceled when patients go to surgery or are transferred to the ICU. The responsible Practitioner shall be notified of impending expiration of an order prior to cancellation of that order. The Practitioner will be responsible for reviewing and resuming/re-writing orders after surgery or transfer from the ICU.

4.2-8 PREPRINTED ORDER SET

When a practitioner is using a preprinted order set, the ordering practitioner shall date, time and authenticate an order by:

(a) Last page: sign, date and time the last page of the orders with the last page also identifying the total number of pages in the order set.

(b) Pages with Internal Selections: sign or initial any other (internal) pages of the order set where selections or changes have been made.
   i. The practitioner shall initial/sign the top or bottom of the pertinent pages(s).
   ii. The practitioner shall also initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made.

Note: It is not necessary to initial every preprinted box that is checked to indicate selection of an order option so long as there are not changes made to the option(s) selected.

In the case of a pre-established electronic order set, the same principles would apply so that the practitioner shall date, time and authenticate the final order that resulted from the electronic selection/annotation process, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.
4.3 DRUGS AND MEDICATIONS

4.3-1 GENERALLY

All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Federal Drug Administration.

4.3-2 MEDICATION RECONCILIATION

Medication must be reconciled by the attending physician within twenty-four (24) hours of admission/entry, at any transition to a higher or lower level of care, and at the time of patient discharge/exit. Blanket orders, such as “continue all home medications” are not acceptable.

4.4 CONSULTATIONS

4.4-1 GENERALLY

Any qualified Practitioner with Clinical Privileges in the Medical Center can be called for consultation within his or her area of expertise.

4.4-2 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. It shall be the responsibility of the Practitioner in charge of the patient to make clear to the consultant whether a consultation alone is requested or a consultation with management is requested. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the Practitioner responsible for the care of the patient. Practitioners contacted for routine consults must respond to the request within twenty-four (24) hours.

4.4-3 CHAIN OF COMMAND

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of his or her supervisor who in turn may refer the matter to the Vice President of Patient Services or the CMO. If warranted, the Vice President of Patient Services or the CMO may bring the matter to the attention of the department chief wherein the Practitioner has Clinical Privileges. Where circumstances are such as to justify such action, the chief of the department may also request a consultation.
4.4-4 URGENT CONSULTS

If the patient is in an emergent situation, the Practitioner should directly contact the consulting Practitioner. The consulting Practitioner must respond immediately or otherwise appropriately consistent with the patient’s condition. If the consulting Practitioner is not available for a consult, the Practitioner who called for the consult shall be responsible for selecting another Practitioner to provide a consult. If the consulting Practitioner desires to obtain a second consult, the consulting Practitioner must receive permission from the Practitioner who called for the original consult.

4.5 ON-CALL ROTATION RESPONSIBILITIES

1. The chairperson of each department, on behalf of the Hospital, shall be responsible for developing an on-call rotation schedule that includes the name and Perfect Serve number of each physician in the department who is required to fulfill on-call duties. On-call rotation schedules shall be maintained in the Emergency Department.

2. Members of the Active Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties by the department chief so that all members share as equitably as possible in Medical Staff responsibilities.

3. The on-call schedule may be general (e.g., medicine or surgery) or by specialty (general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined and implemented by the department chief in accordance with the Medical Staff Bylaws. The Medical Executive Committee shall review the on-call schedule and make recommendations to the Chief Executive Officer when formal changes are to be made or when legal and/or operational issues arise.

4. On call frequency for each specialty shall be determined by the Department Chief and based on provision of the best possible coverage with the available resources. Practitioners with twenty (20) years or more of service at Fairfield Medical Center may be relieved from emergency call responsibilities at the discretion of the Department Chief. Medical Executive Committee, at its discretion, may review and revise call frequency requirements.

5. Transfer arrangements with a hospital that can provide the specialty service shall be made to cover the service when an on-call physician is not available. If a patient presents needing care when a specialty is not covered, the patient shall be transferred in accordance with this Policy.

6. Physicians who have voluntarily limited their practice to include less than the credentialed core privileges typically associated with their specialty may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility. If a physician responds to a call and requires additional expertise to take care of the patient, the physician should attempt to stabilize the patient and request an appropriate consult.

7. When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must do so within a reasonable time
period as specified in the department Rules and Regulations. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient’s condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be controlling in this regard.

8. When discussed with the emergency department physician, the on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including office follow-up related to that episode.

9. A refusal or failure to timely respond shall be reported immediately to the department chief, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action. Otherwise, appropriate action may be imposed.

4.6  TERMINATION OF INPATIENT CARE

4.6-1  GUIDELINES TO BE FOLLOWED WHEN A PHYSICIAN TERMINATES A RELATIONSHIP WITH AN INPATIENT

1. Physician notifies patient and/or responsible relative or responsible person of intent to sever patient physician relationship.

2. Advises he/she will continue physician care through present hospitalization or until patient or responsible relative or person secures replacement physician and of any time limitation involved in present physician's continuing to provide care.

3. If transition of physician care occurs during present hospitalization, resigning physician will brief physician assuming care on patient condition and assure inpatient record is up to date. Resigning physician will provide any other patient records requested by physician assuming care.

4. The resigning physician will dictate an interim hospital summary at the time of the changeover.

5. NOTE: Physicians may have additional duties as designated by the State Medical Board of Ohio which are outside the internal Hospital process.

4.6-2  GUIDELINES TO BE FOLLOWED WHEN A PATIENT OR PATIENT'S RESPONSIBLE PARTY TERMINATES PATIENT-PHYSICIAN RELATIONSHIP WITH AN INPATIENT

1. Patient or responsible party notifies physician of intent to terminate
patient-physician relationship.

2. Physician notifies patient or responsible party of their responsibility to find and secure physician to assume care as hospital inpatients must have a physician responsible for continuing care.

3. Physician being dismissed from case will continue to be responsible for care until relieved by physician assuming care.

4. An interim hospital summary will be dictated by the dismissed physician at the time of the changeover.
PART FIVE
GENERAL RULES REGARDING SURGICAL CARE

5.1 EQUIPMENT AND FACILITIES

The Surgical Medical Staff, the surgical nursing staff, and Administration must maintain adequate facilities for maximum care of surgical patients. The equipment and facilities shall vary from time to time according to the needs and desires of the surgeons.

5.2 OPERATIONAL POLICY FOR THE SURGICAL SUITE

5.2-1 ESTABLISHMENT

Operational policy for the Surgical Suites shall be established jointly by the chiefs of the departments of Anesthesiology, Maternal/Child Health, Orthopedics, and Surgery. Enforcement of such policy for the Medical Staff shall be the responsibility of the chiefs of the respective departments.

5.2-2 COOPERATION

Efficient utilization of the Surgical Suites is the responsibility of the surgery manager and staff. Any lack of cooperation should be reported to the chief of the appropriate department or to the President of the Medical Staff.

5.2-3 SCHEDULING OPERATIONS

Operations will be scheduled as described in the Surgery Policy and Procedure Manual.

5.2-4 EMERGENCY OPERATIONS

Emergency operations will be scheduled as described in the Surgery Policy and Procedure Manual.

5.2-5 CARE AND TRANSPORTATION

Care and transportation of patients to and from the Surgical Suites, within the Surgical Suite and to the Post Anesthesia Care Unit will be described in the Surgery Policy and Procedure Manual.

5.2-6 OHIO LAW

Except in severe emergencies, the surgeon must comply with Ohio Administrative Code 4731-18-01, which includes personal evaluation of the patient, recording a preoperative diagnosis and determining that the patient is a candidate for the
operation to be performed. In an emergency, the Practitioner shall make at least a comprehensive remark regarding the patient’s condition prior to induction of anesthesia at the start of surgery.

5.3 DENTAL/ORAL SURGERY

A patient admitted for dental care or oral surgery is a dual responsibility involving the Oral Surgeon/Dentist and Physician Appointee of the Medical Staff. Oral Surgeons with history and physical examination Clinical Privileges must notify the Physician regarding medical problems of any patients on their service.

5.3-1 DENTIST/ORAL SURGEON RESPONSIBILITIES

The Dentist/Oral Surgeon shall be responsible for:

(a) A detailed dental history justifying Medical Center admission;

(b) If the Dentist/Oral Surgeon has history and physical examination Clinical Privileges in accordance with Section 6.5-1 of the Bylaws, a medical history and general physical examination to determine the patient’s condition prior to anesthesia and surgery (if the Dentist/Oral Surgeon does not has such Clinical Privileges this shall be the responsibility of the Physician);

(c) A detailed description of the examination of the oral cavity in a preoperative diagnosis;

(d) Complete operative report, describing the findings and technique. In cases of extraction of teeth, the Dentist/Oral Surgeon shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the Medical Center Department of Pathology for examination;

(e) Progress notes that are pertinent to the oral condition;

(f) A discharge summary and clinical resume; and

(g) The written discharge orders of the patient.

5.3-2 PHYSICIAN RESPONSIBILITIES

The Physician shall be responsible for:

(a) Medical history and general physical examination to determine the patient’s condition prior to anesthesia and surgery (this shall not apply if the Dentist/Oral Surgeon has history and physical examination Clinical Privileges in accordance with Section 6.5-1 of the Bylaws); and
(b) Supervision of the patient’s general health while hospitalized.

5.4 PODIATRIC PATIENTS

Podiatric patients are co-admitted by the Podiatrist and Physician with dual responsibility for care:

5.4-1 PODIATRIST RESPONSIBILITIES

The Podiatrist shall be responsible for:

(a) A detailed podiatric history justifying Medical Center admission;

(b) A detailed description of the examination of the extremity with a preoperative diagnosis;

(c) Complete operative report, describing the findings and technique. All tissue removed shall be sent to the Medical Center Pathologist for examination;

(d) Progress notes that are pertinent to the podiatric condition;

(e) A discharge summary and clinical resume; and

(f) The written discharge orders of the patient.

5.4-2 PHYSICIAN RESPONSIBILITIES

The Physician shall be responsible for:

(a) Medical history and general physical examination to determine the patient’s condition prior to anesthesia and surgery;

(b) Supervision of the patient’s general health while hospitalized.

5.5 PATHOLOGY REPORTS

All tissues and foreign bodies (unless involved in forensic pathology) removed at the operation shall be sent to the Medical Center Pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. All pathology reports shall be made a part of the patient’s medical record.
6.1 GENERAL PURPOSE

The primary purpose of the Department of Surgery is to ensure appropriate care of surgical patients. This includes the necessity of adequate history and physical examinations and minimum laboratory tests as specified under Section 3.2. It is expected that sufficient information will be recorded on the medical record to substantiate the diagnosis and verify appropriate pre and post operation care. It is the operating surgeon’s responsibility to see that the above are properly entered in the medical record. The operating surgeon may waive the requirement if it is in writing on the chart prior to the administration of the anesthesia. It is the operating surgeon’s responsibility to manage the care of all surgical complications although consultations are encouraged as indicated. Operative permission shall be obtained from each patient and witnessed.

6.2 OFFICERS

6.2-1 CHIEF

Once every two (2) years, the Department of Surgery will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The chief of the department may cancel surgical procedures proposed by members of the Department of Surgery if in the chief’s opinion the procedure is not justified, laboratory reports are not satisfactory or any other situation exists in which the procedures would be unnecessarily dangerous to the life of the patient.

The chief of the Department of Surgery may summarily suspend surgical Clinical Privileges or take any other corrective action in accordance with Articles VII and VIII of the Medical Staff Bylaws.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

6.2-2 VICE CHIEF

The Department of Surgery shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.
6.3 MEETINGS

The Department of Surgery shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual. Time and place may be changed by the chief as desired, as long as each voting member is properly notified. A simple majority of the voting members present shall constitute a Quorum.

6.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Surgery Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

6.5 SURGICAL CLINICAL PRIVILEGES

6.5-1 APPLICATION FORM

New Applicants will request Clinical Privileges on the appropriate form.

6.5-2 QUALIFICATIONS

All Applicants for surgical Clinical Privileges will be considered on an individual basis. They must be either "active candidates" for examination or have successfully completed their examination for certification by their respective surgical specialty boards. Those who are "active candidates" must successfully complete their examination for certification within five (5) years of their original application for surgical Clinical Privileges in this Medical Center. Failure to complete the required examination will result in an automatic suspension of the Practitioner’s surgical Clinical Privileges at the Medical Center.

6.5-3 PROCTORING

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with the Credentials Manual Section 5.4.

6.6 GEOGRAPHIC PROXIMITY

It is the responsibility of each individual Practitioner to be available within a reasonable length of time to provide care and services of that Practitioner’s subspecialty. It is also the responsibility of said Practitioner to provide coverage in the instance of his or her absence to provide a continuum of care. The following response times are guidelines required of Practitioners in the Department of Surgery:

(a) Cardio-Vascular: thirty (30) minutes;
(b) Eye: forty-five (45) minutes;
(c) ENT: forty-five (45) minutes;
(d) General Surgery: thirty (30) minutes;
(e) Plastics: forty-five (45) minutes;
(f) Urology: thirty (30) minutes;
(g) Oral/Maxillofacial: forty (40) minutes;
(h) Neuro/Spine Surgery: thirty (30) minutes.
(i) Orthopedics – forty-five (45) minutes
(j) Podiatry – forty-five (45) minutes

If the guideline response time is unmet by a Practitioner, the incident shall be referred to the department chief for review.
PART SEVEN

DEPARTMENT OF ANESTHESIOLOGY

7.1 OBJECTIVES

To deliver comprehensive anesthesia care of the appropriate standards in a timely, efficient and cost effective manner.

To provide continuing education for its members and encourage their participation.

To provide teaching programs as appropriate for the institution.

To encourage research where possible.

7.2 OFFICERS

7.2-1 CHIEF

Once every two (2) years, the Department of Anesthesiology will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

In accordance with Section 4.8 of the Organization Manual, various sections may be created by the department chief, in conjunction with the MEC, to assist him/her in the performance of his/her duties as chief.

7.2-2 VICE CHIEF

The Department of Anesthesiology shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

7.3 MEETINGS

The Department of Anesthesiology shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.
7.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Anesthesiology Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

7.5 CLINICAL PRIVILEGES

7.5-1 QUALIFICATIONS

New applicants for appointment to the Department of Anesthesiology shall give evidence of the training sufficient to qualify for examination by the American Board of Anesthesiology.

All new members shall either be Board Certified or Eligible.

7.5-2 CLASSES

Class I: Physician who has satisfactorily completed the required residency training to be qualified to sit for or is certified by the American Board of Anesthesiology.

Applicants will be required to fill out the clinical privilege form prepared by the Department of Anesthesiology. He or she will be responsible for providing the necessary information and supportive documents for approval of his or her application for Clinical Privileges.

Class II: Allied Health Professionals with Clinical Privileges in the Department of Anesthesiology.

Delegation of functions to non-Physician personnel shall be based on specific criteria approved by the Department of Anesthesiology.

Clinical Privileges will be granted to AHPs to work under the direct clinical supervision of anesthesiologists. There will be timely and periodic reevaluation of the Clinical Privileges.

7.5-3 PROCTORING

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with the Credentials Manual Section 5.4.

7.6 APPOINTMENTS

All members of the staff shall fulfill duties as assigned by the department chief.
All members of the department shall encourage teaching programs as clinical duties permit.

7.7 CERTIFIED REGISTERED NURSE ANESTHETIST

The provisions regarding Certified Registered Nurse Anesthetists are located in the Allied Health Professional Manual.

7.8 GEOGRAPHIC PROXIMITY

All anesthesiologists must live within a thirty (30) minute radius of the Medical Center. Exceptions may be granted, but if so granted, the anesthesiologist must be within a thirty (30) minute radius of the Medical Center when they have patient care responsibilities.

If the guideline response time is unmet by a Practitioner, the incident shall be referred to the department chief for review.

7.9 TB SCREENING

In compliance with the Ohio Department of Health, all members of the Department of Anesthesiology are required to have yearly TB screening.
PART EIGHT
DEPARTMENT OF OBSTETRICS/GYNECOLOGY

8.1 GENERAL

The Department of OB/GYN shall include Physicians in the practice of obstetrics and/or gynecology, and family practice Physicians with obstetric Clinical Privileges.

8.2 OFFICERS

8.2-1 CHIEF

Once every two (2) years, the Department of OB/GYN will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC. The Chief shall be a Board certified physician practicing in Obstetrics and Gynecology.

The chief of the department may cancel proposed surgical procedures if in his/her opinion the procedure is not justified, laboratory reports are not satisfactory, or any other situation which the procedures would be necessarily dangerous to the life of the patient.

The chief of the Department of OB/GYN may summarily suspend departmental Clinical Privileges or take other corrective action in accordance with Article VII of the Medical Staff Bylaws and the Credentials Manual.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

8.2-2 VICE CHIEF

The Department of OB/GYN shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

8.3 MEETINGS

The Department of OB/GYN shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.
8.4 **QUALITY ASSESSMENT**

Quality improvement activities will be conducted by the Department of Obstetrics/Gynecology Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

8.5 **OBSTETRICS/GYNECOLOGIC CLINICAL PRIVILEGES**

8.5-1 **GENERAL**

Clinical Privileges shall be based on a Practitioner’s training and demonstrated competence and be individualized. A list of the procedures that may be performed in this department is listed on the Department’s Delineation of Clinical Privileges form.

8.5-2 **QUALIFICATIONS**

Any Practitioner who applies to be a member of the Department of OB/GYN must be Board Certified within three (3) years after being approved for Medical Staff Appointment. However, any Practitioner who was approved for privileges at Fairfield Medical Center before July 1, 2000, is not required to be Board Certified in their specialty. Those individuals who do not meet the three (3) year requirement will be reviewed by the Credentials Committee for further action. Any exception or extension must be approved by the Board after review of the recommendation of the Credentials Committee and MEC. The practitioner is expected to maintain Board certification per the practitioner’s specialty Board requirements.

8.5-3 **PROCTORING**

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with the Credentials Manual Section 5.4.

8.6 **PRENATAL CARE**

A detailed record of the prenatal care rendered shall be available to the Labor and Delivery area on forms approved by this department. All information requested on the forms shall be supplied.

8.7 **ADMISSION OF NON-OBSTETRIC PATIENTS**

The use of excess obstetric beds for selected clean gynecological cases aids in the efficient use of beds and may provide a means of preserving an adequate obstetric nursing staff and adequate facilities when the number of deliveries is in a diminishing phase. This use of obstetric beds is encouraged if the following regulations are observed:
(a) An adequate number of obstetric beds must always be available to accommodate peak emergency loads;

(b) Only gynecologic patients with non-infectious conditions should be admitted. (e.g. D&Cs, uncomplicated hysterectomies, tubal ligations and ovarian cysts). No patient who is febrile at the time of admission or in whom there is a reasonable suspicion of infection or invasive cancer will be admitted to or kept in a bed in the obstetric area;

(c) Specific rooms on the postpartum floor shall be used for non-obstetric patients;

(d) The department chief will have the final authority in determining which patients are admitted, and the chief, or a designated representative (such as the chief nurse of the department), should approve each admission;

(e) To ensure these safeguards, such admissions shall be limited to patients of members of the Department of OB/GYN;

(f) Visiting hours and rules for non-obstetric patients should be the same as for the postpartum patients;

(g) The nursing staff should be adequate to provide appropriate care for gynecologic patients without detracting from the care of obstetric patients.

8.8 OB/GYN PRACTITIONERS- GEOGRAPHIC PROXIMITY

All OB/GYN Practitioners must live within a thirty (30) minute response time for providing patient care.

If an obstetrician fails to be available within this time guideline, the incident shall be referred to the department chief for review.

8.9 TB SCREENING

In compliance with the Ohio Department of Health, all members of the Department of Obstetrics/Gynecology are required to have yearly TB screening.

8.10 QUALIFIED MEDICAL PERSONNEL

Registered Nurses working in the obstetrical department are considered Qualified Medical Personnel (QMP) as defined by EMTALA for the purpose of performing the obstetrical screening exam.
PART NINE

DEPARTMENT OF MEDICINE

9.1 GENERAL

The Department of Medicine shall include family practice internal medicine, psychology, psychiatry, neurology and rehabilitative medicine as well as adult and pediatric medical sub-specialties.

9.2 OFFICERS

9.2-1 CHIEF

Once every (2) years, the Department of Medicine will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The chief of the Department of Medicine may summarily suspend medical Clinical Privileges or take any other corrective action in accordance with Article VII of the Medical Staff Bylaws and the Credentials Manual.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

9.2-2 VICE CHIEF

The Department of Medicine shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

9.2-3 SECRETARY

The Department of Medicine will elect one (1) member to be Secretary.

9.3 MEETINGS

The Department of Medicine shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.
9.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Medicine Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

9.5 DEPARTMENT OF MEDICINE CLINICAL PRIVILEGES

9.5-1 QUALIFICATIONS

Any Practitioner who applies to be a member of the Department of Medicine must be Board Eligible or Board Certified in their specialty. The Practitioner must be Board Certified in their specialty within three (3) years after being approved for Medical Staff appointment. Failure to obtain Board Certification within three (3) years from initial appointment will result in automatic suspension of the Physician’s clinical privileges at Fairfield Medical Center.

Each Practitioner and AHP when applying for Clinical Privileges in this department shall request Clinical Privileges for special diagnostic and therapeutic procedures as listed on the appropriate delineation of privileges form.

9.5-2 AREAS

Each Practitioner when applying for Clinical Privileges in this department shall request Clinical Privileges according to criteria established for each of the following general areas:

(a) Family Practice;
(b) Geriatric Medicine;
(c) Internal Medicine & Subspecialties;
(d) Neurology;
(e) Psychiatry;
(f) Psychology;
(g) Radiation Oncology

9.5-3 PROCTORING

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with Credentials Manual Section 5.4.
9.6 SPECIALTY SECTIONS

Medical specialty sections may be established within the Department of Medicine in accordance with Section 4.8 of the Organization Manual. The sections shall include members of the Department of Medicine who are interested in that specialty. The sections of the Department of Medicine are: Internal Medicine, Cardiology and Family Practice.

Quality assessment activities and other functions related to that specialty may be conducted by the section as directed by the department chief. These activities shall be conducted under the auspices of the department and reported at department meetings.

9.7 GEOGRAPHIC PROXIMITY

If the following guideline response time is unmet by a Practitioner, the incident shall be referred to the department chief for review.

9.7-1 INTERNAL MEDICINE

In response to emergency patients, Practitioners on call or covering for other Practitioners must promptly answer pages and be available within a reasonable amount of time depending on the patient’s condition, not to exceed ninety (90) minutes.

9.7-2 FAMILY PRACTICE

Practitioners of the Family Practice section should have a residential proximity within reasonable distance to the Medical Center, subject to Department of Medicine review and approval. Practitioners on call or covering for other Practitioners must promptly answer pages and be available within a reasonable amount of time depending on the patient’s condition, not to exceed forty-five (45) minutes.

9.7-3 CARDIOLOGY

Practitioners who engage in interventional cardiology must be available within a reasonable amount of time depending on the patient’s condition, not to exceed sixty-five (65) minutes.

9.7-4 PHYSICAL MEDICINE AND REHABILITATION

Practitioners who engage in Physical Medicine and Rehabilitation must be available within a reasonable amount of time depending on the patient’s condition, not to exceed sixty (60) minutes.
PART TEN

DEPARTMENT OF PATHOLOGY

10.1 PURPOSE

The primary purpose of the Department of Pathology is to provide pathology and medical laboratory services and consultations to meet the needs of the patient care in accordance with the acceptable standards set up by national accrediting agencies and professional pathology organizations in the discipline of pathology.

Pathology and medical laboratory services on a regular basis and on consultative basis shall be provided by board certified Pathologists who have been certified by the American Board of Pathology or are active candidates for certification. Pathologists must be qualified to assume professional, organizational and administrative responsibilities for the facilities and the services rendered. Board certification is required within two years of initial appointment to the Medical Staff.

10.2 OFFICERS AND DUTIES

10.2-1 CHIEF

Once every two (2) years, the Department of Pathology will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The chief shall be qualified by training, leadership qualities, experience and demonstrated ability for the position by actively engaging in the practice of pathology. He/she shall demonstrate, promote and support excellence in teaching, publications of papers, active research interests and activities of the department, as well as, of the Medical Staff and the Medical Center. The chief shall be certified by the American Board of Pathology in Anatomical and Clinical Pathology. There should be regular consultations with the Laboratory Director on a regular basis related to clinical activities of the Department and all Administrative related activities.

Only appropriately privileged Medical Staff Appointees may utilize department facilities and equipment consistent with department policies.

The chief of the Department of Pathology may summarily suspend Clinical Privileges or take any other corrective action in accordance with Article VII of the Medical Staff Bylaws and the Credentials Manual.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.
10.2-2 VICE CHIEF

The Department of Pathology shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

10.3 MEETINGS

The Department of Pathology shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual to review and evaluate Quality Assessment activities, updates by the Laboratory Manager and administrative staff.

Members must attend at least fifty percent of the regular department meetings.

10.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Pathology Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

10.5 CLINICAL PRIVILEGES

10.5-1 FULL PRIVILEGES

These include all procedures and activities carried out by the department in the following areas:

(a) Anatomic Pathology;

(b) Clinical Pathology;

(c) Personal Patient Services;

(d) Laboratory Directions for various Sections; and

(e) Provide formal and informal consultations to the Medical Staff upon request.

10.5-2 PROCTORING

Proctoring of all individuals granted new clinical privileges shall be conducted in accordance with the Credentials Manual Section 5.4.
10.6 PROCEDURE MANUAL

The Department of Pathology will maintain a manual of policies and procedures pertaining to Nursing Services, Medical Staff and other departments and services as necessary. The procedure manual shall be reviewed yearly and revised as needed. This manual should include information and guidelines needed for patient preparation and collection of specimens.

10.7 PATHOLOGY AND MEDICAL LABORATORY SERVICES

The department shall provide services on a twenty-four (24) hour basis with appropriate technical and clerical staffing.

Monthly schedule for pathologist on call shall be available to all the departments of the Medical Center and Medical Staff.

Members of the Department of Pathology will rotate on nights and weekends, including providing holiday coverage.

The department shall have a safety manual to provide standards, rules and procedures for the safety of the patients and employees.

10.8 GEOGRAPHIC PROXIMITY

As a guideline, Pathologists on call should be no more than forty-five (45) minutes away from the Medical Center.

If the guideline response time is unmet by a Practitioner, the incident shall be referred to the department chief for review.
PART ELEVEN

DEPARTMENT OF EMERGENCY MEDICINE

11.1 GENERAL

The Department of Emergency Medicine shall be organized in accordance with the Medical Staff Bylaws.

The purpose of the Department of Emergency Medicine is to provide the Medical Center and the Medical Staff with a mechanism through which there can be assurance for safe and efficient emergency care.

11.2 OFFICERS

11.2-1 CHIEF

Once every (2) years, the Department of Emergency Medicine will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The chief shall consult with the department manager and administrative staff on the employment of all non-physician personnel who may be required for the proper conduct of the department. The chief shall assist the Medical Staff and administration in every way possible to achieve a high level of patient service with efficiency and economy. The chief shall be actively involved in the future planning of the department and shall assume responsibility of being adequately informed in matters of new technology and treatment to advise the intra-hospital bodies of the needs of the department.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

11.2-2 VICE CHIEF

The Department of Emergency Medicine shall elect one (1) member to be vice chief of the department who will function as chief in the absence of the chief of the department. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.
11.3 MEETINGS

The Department of Emergency Medicine shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.

11.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Emergency Medicine Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

11.5 DEPARTMENT OF EMERGENCY MEDICINE CLINICAL PRIVILEGES

11.5-1 QUALIFICATIONS

Qualifications for membership in the Department of Emergency Medicine are outlined in the Medical Staff Bylaws. The member should be able to demonstrate abilities and competency in the specialty of emergency medicine as defined by the Medical Center’s delineation of Clinical Privileges for Emergency Medicine.

11.5-2 CLINICAL PRIVILEGES

Department of Emergency Medicine Physicians shall be granted Clinical Privileges encompassing all the cognitive and procedural skills necessary for emergency management of acute illness and injuries. The department will develop and keep current an emergency medicine core content skills list. This will be completed upon application for Clinical Privileges in the Department of Emergency Medicine and shall be reviewed by the department chief on a biennial basis or more frequently as required.

The Department of Emergency Medicine skills of any new Physician joining the Department of Emergency Medicine will be reviewed. This review is the responsibility of the department chief.

11.5-3 PROCTORING

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with the Credentials Manual Section 5.4.

11.6 DISASTER PLAN

The Department of Emergency Medicine shall, in cooperation with the MEC and the Medical Center administration, organize a plan for the care of mass casualties at the time of any major disaster, based on the Medical Center’s capabilities in conjunction with other emergency facilities in the community.
11.7 GEOGRAPHIC PROXIMITY

The Department of Emergency Medicine requires each Physician to provide services for the shifts that they are scheduled including “on-call” hours. On-call coverage is limited to four (4) hours prior to or after each shift. The department also double covers with Physicians during high demand times.
PART TWELVE
DEPARTMENT OF RADIOLOGY

12.1 GENERAL

12.1-1 PURPOSE AND COMPOSITION

A physician member of the Department of Radiology shall perform and supervise diagnostic imaging examinations and imaging-guided interventional procedures. Physician members of the department shall be certified by or be eligible for certification by the American Board of Radiology or equivalent certifying body.

12.2 OFFICERS

12.2-1 CHIEF

Once every (2) years, the Active staff members of the Department of Radiology will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC.

The chief shall be an Active member of the Medical Staff and a member of the Department of Radiology. He/she shall be certified by the American Board of Radiology or equivalent certifying body.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

In addition to Section 4.4 of the Organization Manual, the duties and responsibilities of the chief shall include:

1) Discretionary powers regarding the use of the department by non-member physicians.

2) Assuring that procedures are scheduled with appropriate priority.

3) Assisting the Medical Center in assuring the department’s compliance with accreditation and legal requirements.

4) Assisting the Medical Center in promoting cost-effective use of imaging procedures.

Removal of the chief of the Department of Radiology during his/her term of office may be effected by the same process provided for all department chiefs in
the Section 4.7 of the Organization Manual or by the resignation from office of the chief.

12.2-2 VICE CHIEF

The Department of Radiology shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

12.3  DEPARTMENTAL MEETINGS

The Department of Radiology shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.

12.4  QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Radiology Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

12.5  DEPARTMENT COMMITTEES

The Department of Radiology shall maintain standing committees as it deems necessary. Members not otherwise designated shall be appointed by the department chief.

12.5-1 RADIATION SAFETY AND CONTROL COMMITTEE

(a) Membership. Membership of the Radiation Safety Committee should consist of the following:

(i) At least two (2) Appointees of the Medical Staff, including a member from the Department of Radiology;

(ii) Representatives from Nursing and Administration;

(iii) Radiation Safety Officer;

(iv) The chair of the Radiation Safety Committee shall be appointed by the chief of the Department of Radiology;
(v) At least one (1) member of this Radiation Safety Committee must be a radiologist experienced in the safe handling of radioisotopes, in the measurement of radioactivity, and in the determination of radioactivity, and in the determination of radioisotope dosage for various patient studies or treatments; and

(vi) A qualified radiological physicist shall be designated as a consultant to this Radiation Safety Committee.

(b) **Duties.** The duties and responsibilities of the Radiation Safety Committee shall be the following:

(i) To develop, establish and enforce radiation safety rules and policies at the Medical Center to include review of training and experience of persons handling isotopes and provide training as necessary to that end.

(iii) To maintain required radiation safety records and assure compliance with Nuclear Regulatory Commission (NRC) and licensure requirements.

(v) To formulate radiation disaster and emergency procedures.

(vii) To review and approve all requests for use of radioactive material within the institution;

(c) **Meeting Frequency.** The Radiation Safety Committee shall meet at least quarterly.

(d) **Radiation Safety Officer.** The Radiation Safety Officer shall be a physician member of the department or a qualified radiological physicist appointed by the chief whose responsibility shall be to assure that the duties enumerated in Sec. 12.5-2 (b) above are accomplished.

### 12.6 CLINICAL PRIVILEGES

#### 12.6-1 GENERAL

Clinical Privileges in Radiology are granted in accordance with the provisions of Article V and VI of the Medical Staff Bylaws.

Physician members of the department shall be certified by the American Board of Radiology or equivalent certifying body, or be eligible for certification by that
Board and be approved by the chief of the Department of Radiology. A member who is Board Eligible must become Board Certified within five (5) years in order to maintain membership.

The Principles of Ethical Radiological Practice of The American College of Radiology shall govern professional conduct of the members of the radiology staff.

12.6-2 SPECIAL CLINICAL PRIVILEGES

Granting of special clinical privileges in the department to physicians who are not members of the department shall be on a specific and not a blanket basis.

The granting of Special Clinical Privileges shall require at a minimum a letter from a physician qualified to testify to the applicant’s: (a) training and experience in the relevant area and competence equivalent to a radiologist who is a member of the department in that area (b) conformance to established patterns of patient care.

12.6-3 PROCTORING

All physicians requesting special clinical privileges in the department shall be proctored by the chief or his/her designee in accordance with Credentials Manual Section 5.4.

12.7 DEPARTMENTAL PROCEDURE MANUAL

The Department of Radiology will develop and distribute a manual of procedures and policies to be followed in the department.

12.8 DEPARTMENT SERVICES

The Department of Radiology services shall be available on a 24-hour a day basis with appropriate technical staffing.

The rules regarding completion of angiographic and interventional procedure reports shall be those stated in Section 3.4 of this Manual.

12.9 GEOGRAPHIC PROXIMITY

When not physically present at the Medical Center, a Radiologist shall be available for consultation at all times. The radiologist “on call” will be available within forty-five (45) minutes of the Medical Center.
PART THIRTEEN
DEPARTMENT OF PEDIATRICS

13.1 GENERAL

The Department of Pediatrics shall include Physicians in the practice of Pediatrics and family practice Physicians with Pediatric Clinical Privileges.

13.2 OFFICERS

13.2-1 CHIEF

Once every two (2) years, the Department of Pediatrics will elect one (1) member of the department to be chief of the department, subject to the approval of the MEC. The Chief shall be a Board certified pediatrician or a Board certified family physician with experience in Pediatrics.

The chief of the department may cancel proposed surgical procedures if in his/her opinion the procedure is not justified, laboratory reports are not satisfactory, or any other situation which the procedures would be necessarily dangerous to the life of the patient.

The chief of the Department of Pediatrics may summarily suspend departmental Clinical Privileges or take other corrective action in accordance with Article VII of the Medical Staff Bylaws and the Credentials Manual.

The provisions regarding the election, term of office, duties, qualifications, removal, vacancy of the office of department chief are set forth in Article X of the Bylaws and Part 4 of the Organization Manual.

13.2-2 VICE CHIEF

The Department of Pediatrics shall elect one (1) member to be department vice chief who will function as chief in the absence of the department chief. The vice chief shall be elected in accordance with Part 4 of the Organization Manual.

The provisions regarding the duties, qualifications, removal, vacancy of the office of department vice chief are set forth in Part 4 of the Organization Manual.

13.3 MEETINGS

The Department of Pediatrics shall hold meetings in accordance with Article XII of the Bylaws and Section 4.2 of the Organization Manual.
13.4 QUALITY ASSESSMENT

Quality improvement activities will be conducted by the Department of Pediatrics Quality Improvement Committee. Peer review functions will be conducted by the Medical Staff Quality Committee based on Department selected indicators as set forth in their Quality Improvement Plan.

13.5 PEDIATRICS CLINICAL PRIVILEGES

13.5-1 GENERAL

Clinical Privileges shall be based on a Practitioner’s training and demonstrated competence and be individualized. A list of the procedures that may be performed in this department is listed on the Medical Staff Appointment application form.

13.5-2 QUALIFICATIONS

Any Practitioner who applies to be a member of the Department of Pediatrics must be Board Certified within three (3) years after being approved for Medical Staff Appointment. Those individuals who do not meet the three (3) year requirement will be reviewed by the Credentials Committee for further action. Any exception or extension must be approved by the Board after review of the recommendation of the Credentials Committee and MEC.

13.5-3 PROCTORING

Proctoring of all individuals granted new Clinical Privileges shall be conducted in accordance with the Credentials Manual Section 5.4.

13.6 PEDIATRICIANS- GEOGRAPHIC PROXIMITY

All pediatricians should live within a thirty (30) minute radius of the Medical Center when patients are admitted. For extreme emergencies, the nursing staff should contact the nearest Physician available.

If a pediatrician fails to be available within this time guideline, the incident shall be referred to the department chief for review.

13.7 TB TESTING

In compliance with the Ohio Department of Health, all members of the Department of Pediatrics are required to have yearly TB screening.
CERTIFICATION OF ADOPTION AND APPROVAL

This Rules, Regulations and Policies Manual was adopted and recommended to the Board of Directors by the Medical Executive Committee in accordance with and subject to the Medical Staff Bylaws.

President of the Medical Staff  Date

Chief Medical Officer  Date

This Rules, Regulations and Policies Manual was approved and adopted by the Board of Directors, after considering the Medical Executive Committee’s recommendation and in accordance with and subject to the Medical Center’s Bylaws.

Chair, Board of Directors  Date

Medical Center President  Date