

Rules and Regulations

**COMMUNITY HOSPITALS AND WELLNESS CENTERS
BRYAN HOSPITAL**

A Medical Staff Document

I. Definitions

The definitions set forth in the Medical Staff Bylaws shall apply to these Medical Staff Rules & Regulations unless a different definition is otherwise specified herein.

II. Admission of Patients

A. Patients may be admitted to the Hospital by Practitioners or Advanced Practice Providers (APP) (subject to the conditions set forth below) with admitting Privileges.

1. Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), Certified Nurse Midwives (CNM), and Physician Assistants (PA) may admit patients to the Hospital if all of the following conditions are met:

- a. The CNP, CNS, or CNM has a Standard Care Arrangement (SCA) entered into, in accordance with applicable Ohio law, with a collaborating Physician or Podiatrist who is a member of the Medical Staff with Clinical Privileges including the ability to admit patients.
- b. The PA is listed on a Supervision Agreement entered into, in accordance with applicable Ohio law, for a Physician or Podiatrist who is a member of the Hospital's Medical Staff with Clinical Privileges including the ability to admit patients.
- c. The patient is under the medical supervision of the collaborating or supervising Physician or Podiatrist.
- d. The CNP, CNS, CNM, or PA has been granted the privilege of admitting patients to the Hospital.
- e. Prior to admitting a patient to the Hospital, the CNP, CNS, CNM, or PA must notify his/her collaborating or supervising Physician or Podiatrist of the planned admission.

2. For purposes of these Rules & Regulations, in the event an APP has been granted admitting Privileges, then references to the admitting/attending/responsible Practitioner shall include the admitting APP to the extent permitted by applicable laws, rules, and regulations, the APP's Privileges and standard care arrangement or supervision agreement, and as applicable to the admitting APP's responsibilities toward his/her patient.

B. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been documented. In case of an emergency, the provisional diagnosis shall be documented as soon after admission as possible.

- C. Practitioners or APPs admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who the Practitioner or APP has reason to believe may be a source of danger or to assure protection of the patient from self-harm.
- D. Patients shall be attended by a hospitalist or the patient's private Practitioner/APP or covering Practitioner. Patients admitted through the Emergency Room who have no attending Practitioner/APP shall be assigned a Practitioner on duty with appropriate Privileges.
- E. All patients admitted to the Hospital must be under the care of an appropriate Practitioner/APP with Privileges consistent with applicable laws, rules, and regulations including, but not limited to the, Medicare hospital conditions of participation.

III. Medical History & Physical Examination ("H&P")

A. Elements of an H&P

1. Inpatients, Observation Patients, and Swing Bed (Skilled) Patients:

- a. H&Ps for inpatients, observation patients, and swing bed (skilled) patients must include, at a minimum, the following:
 - i. History of present illness
 - ii. Past medical history
 - iii. Allergies
 - iv. Current medications
 - v. Review of systems
 - vi. Physical exam
 - vii. Heart and lung assessment
 - viii. Neurological assessment
 - ix. Target organ assessment for reason for hospitalization
 - x. Diagnosis
 - xi. Plan of care

2. Outpatients Undergoing Invasive Procedures:

- a. H&Ps for outpatients undergoing invasive procedures with local anesthesia in the OR must include, at a minimum, the following:
 - i. History of present illness
 - ii. Past medical history
 - iii. Allergies
 - iv. Current medications
 - v. Target assessment of organ/body part of planned procedure
 - vi. Diagnosis
 - vii. Plan of care
- b. H&Ps for outpatients undergoing invasive procedures with Moderate Sedation, Monitored Anesthesia Care (MAC/Deep Sedation), regional, or general anesthesia in the OR, Catheterization Lab, or Radiology must include, at a minimum, the following:
 - i. History of present illness
 - ii. Past medical history
 - iii. Allergies
 - iv. Current medications
 - v. Review of systems
 - vi. Physical exam
 - vii. Heart and lung assessment
 - viii. Neurological assessment
 - ix. Target organ assessment for reason for hospitalization,
 - x. Mallampati assessment for cardiac procedures (specific form)
 - xi. Diagnosis
 - xii. Plan of care

B. Requirements of H&P

1. Patients shall, as applicable, receive a medical history and physical examination no more than thirty (30) days prior to or within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to registration or admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or admission, but prior to surgery or a procedure requiring anesthesia services. The update shall be based on an appropriate reassessment of the patient which should include a physical examination of the patient sufficient to update those components of the patient's current medical status that may have changed and to address any areas where more current data is needed since the H&P was completed.
2. The H&P shall be completed and documented by a Physician, an Oral & Maxillofacial Surgeon, or other qualified licensed individual who is granted the Privileges by the Hospital to do so in accordance with State law and Hospital policy.
3. Additional information regarding H&Ps is set forth in the Medical Staff Bylaws.

IV. Orders

- A. Orders. All orders shall be in writing or electronically entered and authenticated, dated, and timed by the ordering Practitioner or APP. The Practitioner's or APP's orders must be clear, legible (if written), and complete.
 1. Practitioners shall have the authority to issue orders as permitted by their Privileges subject to applicable laws, rules, and regulations.
 2. The ability of an APP to issue orders, if any, shall be as defined in the applicable APP Privilege set. All APP orders must be (i) permitted by the APP's license and within the APP's scope of practice; (ii) within the APP's delineated Privileges; (iii) consistent with the APP's standard care arrangement or supervision agreement; and (iv) in accordance with all applicable laws, rules, regulations, and Hospital and Medical Staff policies.
- B. Verbal/Telephone Orders. Verbal and telephone orders are permitted but must be used infrequently and must not be a common practice. Verbal and telephone orders should be used only to meet the care needs of a patient when it is impossible or impractical for the ordering Practitioner or APP to write or electronically enter the order without delaying treatment. Verbal and telephone orders shall be signed, dated, and timed by the person to whom dictated with the name of the ordering Practitioner or APP.
 1. Authentication of Verbal/Telephone Orders. Verbal and telephone orders must be authenticated, dated, and timed promptly by the ordering

Practitioner/APP or another Practitioner who is covering for the ordering Practitioner/APP and responsible for the care of the patient.

2. Receipt and Documentation. Only designated licensed personnel, as specified in applicable Hospital policy (as such policy may be amended from time to time), are authorized to receive and document verbal and telephone orders within their scope of practice.
 3. Read-Back. All verbal and telephone orders require read-back verification of the complete order with the ordering Practitioner/APP.
- C. Orders Cancelled Prior to Surgery. All previous orders are canceled when patients go to surgery except those that are exempt under Hospital policy, as such policy may change from time to time. The Practitioner or APP must issue new orders, as applicable, following the patient's surgery and may not write "resume previous orders."
- D. Outpatient Orders. Hospital outpatient services may be ordered (and patients may be referred for Hospital outpatient services) by a Practitioner or Ohio APP who is (i) responsible for the care of the patient; (ii) licensed in, or holds a license recognized in, the jurisdiction where he/she sees the patient; (iii) acting within his/her scope of practice under State law; and (iv) authorized by the Medical Staff to order the applicable outpatient services under these Rules & Regulations and/or applicable Hospital policy as approved by the Board.

V. Medical Records

A. Authentication of Medical Record Entries

1. "Authentication" means to establish authorship by written signature, identifiable initials, electronic signature/computer key, or other code.
2. For authentication, in written or electronic form, a method must be established to identify the author.
3. Authorized users of electronic authorizations shall sign a statement assuring that they alone will use the electronic signature/computer key or code.

B. Content of Medical Record

1. The medical record contains the following demographic information as applicable:
 - a. The patient's name, address, and date of birth, and the name of any legally authorized representative
 - b. The patient's sex, race, and ethnicity.

- c. The legal status of any patient receiving behavioral health care services
 - d. The patient's communication needs, including preferred language, for discussing health care
2. The medical record contains the following clinical information as applicable:
- a. The reason(s) for admission or for care, treatment, and/or services
 - b. The patient's initial diagnosis, diagnostic impression(s), and condition(s)
 - c. Any findings of assessments and reassessments
 - d. Any allergies to food
 - e. Any allergies to medications
 - f. Any conclusions or impressions drawn from the patient's medical history and physical examination
 - g. Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections)
 - h. Any consultation reports
 - i. Any observations relevant to care, treatment, and/or services
 - j. The patient's response to care, treatment, and/or services
 - k. Any emergency care, treatment, and/or services provided to the patient before his or her arrival
 - l. Any progress notes
 - m. All orders
 - n. Any medications ordered or prescribed
 - o. Any medications administered including the strength, dose, and route
 - p. Any access site for medication, administration devices used, and rate of administration
 - q. Any adverse medication reactions

- r. Treatment goals, plan of care, and revisions to the plan of care
 - s. Results of diagnostic and therapeutic tests and procedures
 - t. Any medications dispensed or prescribed on discharge
 - u. Discharge diagnosis
 - v. Discharge plan and discharge planning evaluation
3. As needed to provide care, treatment, and/or services, the medical record contains the following additional information:
- a. Any advance directives
 - b. Any informed consent, when required by Hospital policy
 - c. Any records of communication with the patient, such as telephone calls or emails
 - d. Any patient-generated information
4. The medical record of a patient who receives urgent or immediate care, treatment, and/or services contains all of the following:
- a. The time and means of arrival
 - b. Indication that the patient left against medical advice, when applicable
 - c. Conclusions reached at the termination of care, treatment, and/or services including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and/or services
 - d. A copy of any information made available to the Practitioner or medical organization providing follow-up care, treatment, and/or services
5. Other information as required by applicable laws, rules, regulations, and/or accreditation standards.

C. Operative/Other High-Risk Procedure Reports

1. A full operative or other high-risk procedure report must be dictated within twenty-four (24) hours after the completion of the operation. The operative or other high-risk procedure report includes the following information:
- a. Name and Hospital identification number of the patient

- b. Dates and times of the surgery
- c. Name(s) of the surgeon(s)/Practitioner(s) who performed the procedure and his/her assistant(s) or others who performed surgical tasks even when performing those tasks under supervision
- d. Description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/Practitioner including opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, or altering tissues
- e. Preoperative diagnosis
- f. Name of the procedure performed
- g. Type of anesthesia administered
- h. A description of the procedure/techniques
- i. Findings of the procedure
- j. Complications, if any
- k. Any estimated blood loss
- l. Any specimen(s)/tissues removed or altered
- m. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
- n. Postoperative diagnosis

D. Post-Operative/High-Risk Procedure Progress Notes

- 1. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, the Practitioner must enter an immediate post-operative/procedure progress note in the medical record following the operation or other high-risk procedure and before the patient is transferred to the next level of care in order to ensure uninterrupted and continuous care of the patient. This progress note includes:
 - a. Name(s) of the primary surgeon(s) or Practitioner(s) performing the procedure and other assistant(s)
 - b. Procedure performed
 - c. Description of each procedure finding

- d. Estimated blood loss
 - e. Specimens removed
 - f. Postoperative diagnosis
- E. Discharge Summary. The medical record shall contain a discharge summary or final progress note in accordance with the requirements set forth in Section XII of these Medical Staff Rules & Regulations.
- F. Progress Notes. Progress notes shall be recorded at the time of examination to facilitate continuity of care. Each of the patient's clinical problems should be clearly defined in the progress notes and correlated with specific orders as well as the results of tests and treatments. Progress notes shall be entered into the medical record at least daily.
- G. Timely Completion of Medical Records
 - 1. All medical records must be completed within 30 days following the patient's discharge or outpatient care.
 - 2. Practitioners and APPs shall be notified of any medical records that are incomplete within ten (10) days after the date of completion of service, and the Practitioner or APP shall have until thirty (30) days after the completion of service to complete such medical records. A follow up phone call will be made to the Practitioner or APP no later than twenty-five (25) days after completion of service to set up a time for the Practitioner or APP to complete medical records that remain incomplete. Medical records that remain incomplete beyond thirty (30) days of service are delinquent. The Practitioner's or APP's Privileges will be automatically suspended as of the 31st day. The automatic suspension will be communicated to the Practitioner or APP in writing and will take effect immediately.
 - 3. A Practitioner or APP whose Privileges are automatically suspended may not, as applicable, exercise any Privileges at the Hospital, participate in Emergency Room Call, schedule surgery, or otherwise provide professional services within the Hospital for patients with the exception that such Practitioners or APPs may:
 - a. Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.
 - b. Attend an obstetrical patient who has been under his or her active care and management and who comes to term and is admitted to the Hospital in labor.

- c. Attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension.
 - d. Attend to the management of any patient requiring emergency care and intervention.
- 4. An automatic suspension will continue until such time as all of the Practitioner's or APP's delinquent medical records are completed. If a Practitioner's or APP's Privileges are automatically suspended three (3) or more times in one (1) Medical Staff Year for delinquent medical records, the Practitioner or APP will be referred to the Credentials Committee for review and appropriate follow up action.
- H. Property/Release of Medical Records. Information regarding medical records and release of information contained within medical records is set forth in the Hospital's Health Information Management policies and procedures as such policies and procedures may be amended from time to time.
- I. Access to Medical Records
 - 1. Access to medical records of all patients shall be afforded to Practitioners in Good Standing and APPs, to the extent applicable, for bona fide study and research subject to preservation of the confidentiality of personal information concerning the individual patients, MEC approval of the research, and compliance with all applicable federal and state laws, rules, and regulations (*e.g.*, governing the confidentiality of medical records, *etc.*).
 - 2. Subject to the discretion of the Chief of Staff and CEO and all applicable federal and state laws, rules, and regulations governing the confidentiality of medical records, former Practitioners and APPs shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
 - 3. In the case of readmission of a patient, the patient's previous medical records shall be available via the electronic health record for reference by the treating providers.

VI. Medications

- A. All medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia-National Formulary with the exception of medications for *bona fide* clinical investigations or other justified exceptions as determined on a case-by-case basis by the Pharmacy and Therapeutics Committee and MEC.
- B. A Practitioner or, if applicable, an APP requesting use of an investigational drug for treatment of a specific inpatient must:

1. Use such investigational medications in accordance with applicable FDA regulations.
 2. Consult with and obtain approval from the Pharmacy and Therapeutics Committee chair and the Institutional Review Board of the Hospital.
 3. Obtain informed consent from the patient or the patient's legal guardian(s) or authorized representative(s).
- C. To ensure that the medication therapy of an individual patient is reviewed on a regular basis by the prescribing Practitioner/APP, compliance with Hospital policies MED00025 (Hard Stop Date Orders) and PHARM166 (Hard Stop Order Report Run Procedure), as such policies may be amended from time to time, is expected.
- VII. Consent. A general consent form must be signed by or on behalf of every patient treated at the Hospital. Except in cases of emergency, an appropriate informed consent must be obtained from the patient or his/her legal guardian or authorized representative by the treating Practitioner prior to performance of designated treatments or procedures. Additional requirements with respect to informed consent are set forth in applicable Hospital policy as such policy may be amended from time to time
- VIII. Sterilization. Requirements for consent for sterilization shall be in accordance with applicable Ohio laws, rules, and regulations, and Hospital policy, as such policy may be amended from time to time.
- IX. Induction of Labor. The Physician or Certified Nurse Midwife who induces labor on a patient shall be readily available at all times while the induction is in progress. A Physician with Privileges to perform cesarean sections must also be readily available.
- X. Coverage. Practitioners must be available to provide continuous care to their patients or make arrangements for appropriate coverage in the Practitioner's absence in accordance with the requirement set forth in the Medical Staff Bylaws. In the event that both the Practitioner and covering Practitioner are not available, the CEO or designee shall have the authority to call any Appointee with appropriate Privileges to provide care, treatment, and/or services. APPs must be available to provide continuous care to their patients or make arrangements for appropriate coverage in the APP's absence with his/her collaborating or supervising Practitioner or another APP with appropriate Privileges.
- XI. Call Coverage. It is the policy of the Hospital to assure the emergency department is adequately covered by on-call Physicians and, as applicable, other Practitioners with Medical Staff appointment and Privileges at the Hospital, consistent with the services provided at the Hospital and the resources the Hospital has available, according to a schedule for such coverage. The following response times are guidelines:
- A. On-call Practitioners should respond by telephone within ten (10) minutes after being contacted by the Hospital. On-call Practitioners should arrive at the Hospital

within a reasonable period of time after being contacted as is medically appropriate as dictated by the patient's condition.

1. On-call Physicians responding to a Cesarean Section should respond by telephone within ten (10) minutes after being contacted by the Hospital and arrive at the Hospital to begin the procedure (*e.g.*, make the incision) within thirty (30) minutes after being contacted.
 2. Physicians on-call for newborn care should respond by telephone within ten (10) minutes after being contacted by the Hospital and arrive at the Hospital within thirty (30) minutes after being contacted.
 3. Physicians on-call for Stemi Cath Lab should respond by telephone within ten (10) minutes after being contacted by the Hospital and arrive at the Hospital within thirty (30) minutes after being contacted.
- B. Practitioners who treat patients while on-call shall be responsible for treating the patient through the acute emergency phase of their treatment and for any necessary office follow-up care related to the emergency visit. Such treatment shall not be based on or limited by the patient's ability to pay.

XII. Medical Screening Examination

- A. Qualified personnel for purposes of conducting a medical screening examination of a patient who presents to the Emergency Department shall be defined to mean a/an:
1. Physician or other Practitioner (within such Practitioner's scope of practice).
 2. PA or CNP, as applicable, within such PA's or CNP's scope of practice.
 3. In the case of obstetrical patients, an appropriately trained Labor and Delivery registered nurse, within the RN's scope of practice, in consultation with and under the supervision of an appropriately privileged Physician OB/GYN.

XIII. Discharge and Discharge Summary

- A. Patients shall be discharged only on order of the responsible Practitioner or APP (granted Privileges to admit patients to the Hospital).
- B. A discharge summary shall be entered into the medical record within fifteen (15) days after discharge. A discharge summary shall address the:
1. Reason for hospitalization.
 2. Procedures performed.

3. Care, treatment, and services provided.
 4. Outcome of hospitalization; or, for outpatient records, the outcome of treatment, procedures, or surgery.
 5. Patient's condition and disposition at discharge.
 6. Information provided to the patient and/or his/her legal guardian or authorized representative.
 7. Provisions for follow up care.
- C. A discharge summary is not required when a patient is seen for minor problems or interventions as defined by the Medical Staff. In this instance a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

XIV. Patient Death

A. Pronouncement of Death

1. Only a Physician may declare a patient dead at the Hospital.
2. Pronouncement of death shall be in accordance with the requirements set forth in applicable Hospital policy as such policy may be amended from time to time.

B. Autopsies

1. The coroner shall be notified regarding patient deaths that meet coroner criteria for autopsy in accordance with applicable laws, rules, and regulations.
2. The Medical Staff should attempt to secure autopsies in all cases of unusual deaths and of medical, legal, and educational interest. The Medical Staff, and specifically the attending Practitioner, is notified when an autopsy is being performed.
3. The mechanism for documenting permission to perform a Practitioner ordered autopsy shall be as set forth in applicable Hospital policy, as such policy may be amended from time to time.
4. Autopsies shall be performed by a pathologist or at a contracted health care facility and transportation will be arranged.
5. The provisional and final diagnosis will be made part of the medical record.

XV. Operations

- A. Requirements with respect to post-operative reports and progress notes are set forth in Section V (C) and Section V (D) of these Rules & Regulations
- B. Tissues removed during surgery shall be sent to the Hospital pathologist unless otherwise exempt per applicable Hospital policy, as such policy may be amended from time to time. The Hospital pathologist shall conduct such examination as he/she may consider necessary to arrive at a pathological diagnosis and he/she shall authenticate, date, and time his/her report, which shall become a part of the patient's medical record.
- C. Except in emergencies, the pre-operative diagnosis, H&P, and ordered laboratory and diagnostic test results must be recorded on the patient's medical record prior to any surgical procedure. In an emergency the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of the surgical procedure.
- D. Anesthetists (*i.e.*, anesthesiologist, CRNA) and surgeons must be in the operating room and ready to commence surgery at the time scheduled and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled.
- E. The anesthetist (*i.e.*, anesthesiologist, CRNA) shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation of systems and post-anesthesia follow-up of the patient's condition.
 - 1. A pre-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to any inpatient or outpatient surgery or a procedure requiring anesthesia services. The pre-anesthesia evaluation of the patient includes, at a minimum:
 - a. Elements that must be performed within the 48-hour timeframe:
 - i. Review of the medical history, including anesthesia, drug and allergy history
 - ii. Interview, if possible given the patient's condition
 - iii. Examination of the patient.
 - b. Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days prior to the 48-hour time period, in preparation for the procedure:
 - i. Notation of anesthesia risk according to standards of practice (*e.g.* ASA classification of risk).

- ii. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (*e.g.* difficult airway, ongoing infection, limited intravascular access).
 - iii. Additional pre-anesthesia data or information, if applicable and required in accordance with standard practice prior to administering anesthesia (*e.g.* stress tests, additional specialist consultation).
 - iv. Development of the plan for the patient's anesthesia care including the type of medications for induction, maintenance, and post-operative care; and, discussion with the patient or the patient's legal guardian(s) or authorized representative(s) of the risks and benefits of the delivery of anesthesia.
- 2. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with Hospital policies and procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care. The elements of an adequate post-anesthesia evaluation should conform to current standards of anesthesia care including:
 - a. Respiratory function including respiratory rate, airway patency, and oxygen saturation
 - b. Cardiovascular function including pulse rate and blood pressure
 - c. Mental status
 - d. Temperature
 - e. Pain
 - f. Nausea and vomiting
 - g. Postoperative hydration

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

- F. Major operations, as defined by the Surgical Services Committee, shall typically include a qualified First Assistant.

- G. The criteria for determining the anesthesia services Privileges to be granted to a Practitioner or APP (*e.g.*, a CRNA) and the procedure for applying the criteria to Practitioners or APPs requesting Privileges for any type of anesthesia services shall be generally set forth in the Medical Staff Bylaws and APP Policy and detailed in applicable Hospital/Medical Staff policies and Privilege sets, as such documents may be amended from time to time.
 - H. CRNAs administering general, regional, and monitored anesthesia shall be supervised by the operating Practitioner who is performing the procedure. The Hospital permits the operating Practitioner to supervise CRNAs administering anesthesia for those procedures for which the operating Practitioner has been granted Clinical Privileges.
- XVI. Prenatal Medical Records. Prenatal medical records will be made a part of the mother's inpatient medical record upon delivery of a newborn.
- XVII. Disaster Assignments. At the time of any disaster, Practitioners and APPs will be governed by the applicable provisions of the Medical Staff Bylaws or APP Policy, as applicable, and the Hospital Disaster Plan as written and integrated with the Civil Defense of Williams County and Community Hospitals and Wellness Centers.
- XVIII. Compliance. It is the policy of the Medical Staff to comply with all federal and state laws, rules, and regulations pertaining to the delivery of health care in a hospital setting. Each Practitioner and APP is expected to maintain compliance with applicable state and federal laws, rules, and regulations including, but not limited to, the Medicare hospital conditions of participation and applicable accreditation standards governing the Hospital and the delivery of health care in the Hospital.
- XIX. Consultations
- A. Any Practitioner with Privileges can be called for consultation within the Practitioner's area of expertise.
 - B. Consultations are recommended when, in the judgment of the attending Practitioner:
 - 1. There is doubt as to the best therapeutic measures to be utilized.
 - 2. When requested by the patient or patient's legal guardian(s) or authorized representative(s).
 - 3. To manage a medical condition outside the scope of the attending Practitioner's expertise.
 - C. A satisfactory consultation includes examination of the patient, review of the patient's medical record, and documentation of the opinion of the consultant in the patient's medical record.

- D. A consultation for an inpatient or observation patient is to be completed within twenty-four (24) hours after notification of the order.
 - E. When operative procedures are involved, the consultation note should be recorded prior to the operation, except in an emergency.
 - F. The patient's Practitioner is responsible for requesting consultation and communicating the reasons for a consultation. Practitioner to Practitioner communication to request a consultation is preferred.
 - G. A PA or CNP with Privileges at the Hospital may request a third party consultation in cooperation with his/her supervising or collaborating Practitioner. A PA or CNP who is granted Privileges to do so may provide a consultation within his/her scope of practice if requested to do so in accordance with the requirements, as applicable, set forth in this section.
- XX. Restraints. Restraints shall be used (1) only when all other interventions have been exhausted and (2) consistent with the Hospital's Restraint Policy as set forth in its Nursing Procedure Manual, as such policy may be amended from time to time.
- XXI. Advanced Directives. The Hospital will, to the best of its ability, recognize legal documents pertaining to Living Wills, Durable Power of Attorney for Health Care, Do Not Resuscitate Comfort Care, Do Not Resuscitate Comfort Care-Arrest, and Declarations for Mental Health Treatment that are appropriately and properly executed as recognized under Ohio law. Additional information with respect to Advanced Directives and Do Not Resuscitate orders is set forth in applicable Hospital policy, as such policy may be amended from time to time.