

DAYTON CHILDREN'S HOSPITAL
PROFESSIONAL STAFF
RULES AND REGULATIONS

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DAYTON CHILDREN'S HOSPITAL
RULES AND REGULATIONS

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GENERAL. RULES AND REGULATIONS

These Rules and Regulations are established as directives and procedures for patient care and are to be followed unless clearly contrary to the best interests of the individual patients. Circumstances and conditions affecting patients may vary so that it is not humanly possible to foresee and provide for every situation that may arise. Interpretation and application of these Rules and Regulations shall always be made in this spirit: the needs and welfare of the patient must come first.

ADMISSIONS

A. Provisional Diagnosis: Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated and the consent of the admitting physician secured. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

B. Surgical Admissions: Surgical operations shall be performed only with the consent of the patient or his/her legal representative except in circumstances in which delay of appropriate treatment due to unavailability of patient's legal representative would result in loss of life, limb or other major bodily functions.

C. Patients: Dayton Children's Hospital (DCH) ordinarily shall admit patients suffering from any disease and shall refuse patients only when services are not available, or when the proper facilities are not available for the care of the patient. It shall be the responsibility of the attending physician or dentist to always inform the hospital's medical authority of a condition pertaining to the patient which might be medically dangerous to others. The mission of Dayton Children's Hospital, in part, is to provide comprehensive health care to our patients from birth through twenty-one (21) years of age. Availability of services for adults twenty-two (22) years of age and older will depend upon the competency of staff and the specific area of the hospital where service is to be provided. For further guidelines regarding adult care at Dayton Children's Hospital, see the hospital policy *Adult Care*

D. Protection of Other Persons: Physicians and dentists admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatever or to assure the protection of the patient from self-harm.

E. Admission Laboratory Work: The requirements for preoperative lab work will be established by policy of the division of anesthesiology and the Department of Surgery.

F. Assignment of Cases: Service patients shall be attended by a member of the Professional Staff and shall be assigned to the department or section concerned in the treatment of the disease which necessitated admission.

Private patients shall be attended by their own private physician or dentist. In the case of the patient applying for admission who has no attending physician or dentist and does not elect or is unable to choose one, he/she shall be assigned to a member of the Professional Staff on duty on the service to which the illness of the patient indicated assignment, or to the staff service. Quality care dictates daily contact with patients. Attending physicians or their associates (e.g. partner, not resident) are required to see their patients on a daily basis and write their own progress note or cosign the resident's note.

G. Dental Admissions: All patients admitted to the hospital by a dentist shall have a completed history and physical examination by the patient's private attending physician, or in the case of service patients, by an assigned attending physician performing this service. The attending physician shall determine the patient's condition prior to and suitability for anesthesia and surgery. In all cases, the attending physician conducting the history and physical examination shall be a member of the professional staff of Dayton Children's Hospital, and he/she or his/her designee (associate; not resident) shall be available for medical care consultation throughout the patient's admission. Board certified oral surgeons may do their own history and physical examination on patients who are categorized as ASA I and II (anesthesia patients with minimal risk of anesthesia complications and no organic disease).

H. Admissions to the Pediatric Intensive Care Unit: The Pediatric Intensive Care Unit (PICU) will be a closed unit, and only physicians who are board certified or eligible in pediatric critical care

medicine will be permitted to admit medical patients to the PICU. Surgical patients admitted to the PICU will be admitted to the respective surgical services with the pediatric critical care physician participating in a collaborative co-management relationship with the surgeon of record.

The Immediate Care Unit (IMCU) is not a closed medical unit. The pediatric critical care physicians will be available, however, for consultation on all patients admitted to the IMCU.

I. Admissions to the Neonatal Intensive Care Unit: Upon admission of an infant to the Neonatal Intensive Care Unit (NICU) all cases will be reviewed by pediatric or surgery resident or the Neonatal Nurse Practitioner (NNP) (as appropriate). All patients will then be assigned to a resident for continuing care under the supervision of an attending physician.

The attending physician will be ultimately responsible for the care of the patient. Upon admission to the NICU, the resident/NNP will contact the attending physician immediately. The attending physician will then decide further care needs of the patient. The attending physician should see the patient within a period of time commensurate with the medical needs of the patient. If there is any significant change in the condition of the patient, the attending physician should be called immediately by the resident/NNP.

J. Admissions to the Pediatric Trauma Service: All children and adolescents admitted to the inpatient service at DCH or to the Almost Home Unit (AHU) with a trauma related diagnosis are appropriately evaluated for systemic manifestations of trauma. Therefore, all trauma patients who are admitted to an inpatient service at DCH or to the AHU must be admitted either to a service included in the trauma panel (Pediatric Surgery, Neurosurgery or Orthopedics) or to a specialty surgical service with a consult to the Pediatric Surgery Service as needed. Trauma patients should not be admitted to a medical pediatric generalist or specialist without the prior approval of the Trauma Surgeon on call or Trauma Medical Director. While critically injured children requiring admission to the pediatric intensive care unit are admitted to the Trauma Service, co-management by the intensivist is necessary to ensure the level of care needed. This requires many of the daily medical care requirements to be managed by a dedicated PICU team with communication to the trauma team. Joint rounds between the pediatric trauma surgeon and the PICU team assure enhanced communication and a single plan of care for critically injured patients. Once admitted to the appropriate surgical service, consultations to the primary care physician or medical specialty consultant are strongly recommended.

The following addresses a number of special circumstances that may occur and their recommended management. When cases are appropriate for medical admissions and management, there must be a consult by the Trauma Service to screen for associated injuries.

1. Non-accidental trauma (NAT or R/O Inflicted Trauma) – will be admitted to the Trauma Service. The following describes the exception to this rule.
 - a. NAT may be admitted to the Medical Pediatric Service after consultation with the Trauma Service if the injuries are minor and do not, in and of themselves, require admission.
 - b. The Trauma Service assumes initial responsibility for the care of the NAT patient throughout the acute phase of hospitalization. If after thorough evaluation of the NAT patient by the Trauma Service and co-managing services, the Trauma attending makes the determination that the major surgical aspects of the patient's care have been addressed; the care may be transferred to the most appropriate surgical/medical service. The Trauma Service and the receiving service must be in agreement before a change in the admitting service is made.
2. Asphyxiation injuries – can be admitted to the appropriate medical service. Such injuries include:
 - a. Near-drowning without concurrent injuries
 - b. Hangings without concurrent injuries
 - c. Smoke inhalation patients without significant burns or other concurrent injuries

3. Patients with electrical injuries without cutaneous burns may be admitted to the intensivists.
4. Other diagnoses – if there is uncertainty over the appropriate service to handle the child with potential injury, admit to the most appropriate service after consultation with the trauma surgeon on call.

K. Transfer of Patients: When DCH does not provide the services or have the proper facilities required by a patient, such as those patients requiring substance abuse and/or psychiatric care, or DCH for any reason cannot admit a particular patient who requires inpatient care, the hospital or the attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. If the patient is to be transferred to another health care facility, the responsible physician shall enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient. The Emergency Medical Treatment and Active Labor Act (EMTALA) defines the responsibilities of DCH and the professional staff, as they relate to evaluation, stabilization and transport of patients. Current information which outlines EMTALA requirements is available in the emergency department.

ALTERNATES

Each member of the Professional Staff not residing within a reasonable distance shall name a local resident member of the Professional Staff who may be called to attend the patient in an emergency. In case of failure to name such an associate, the Vice President for Medical Affairs of the hospital or the Head of the particular Division shall have authority to call any member of the staff, shall either consider it necessary.

AUTOPSY

Every member of the professional staff is expected to take an active part in securing permission for autopsies upon patients who have died in the hospital under his/her care or for whom he/she has provided consultative services. This includes patients who present to the emergency department (ED) and are declared dead in the ED. Professional staff members should consult the hospital policy on Care of the Deceased Patient for additional information. The coroner is notified of every death that occurs at DCH. If the coroner waives the right to perform an autopsy, professional staff members at DCH should seek permission of the family to allow an autopsy by DCH pathologists. Because of the rarity of death in pediatric patients, an autopsy should be considered in the death of any pediatric patient. The College of American Pathologists suggests autopsies be performed in the following circumstances:

1. deaths in which the autopsy might help to explain unknown and unanticipated medical complications to the attending physician
2. all deaths in which the cause of death is not known with certainty on clinical grounds
3. cases in which the autopsy may help to allay the concerns of the family regarding the death and to provide reassurance to the family regarding the cause of death
4. unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedure or therapy
5. death of patients who are participating in clinical trials approved by the Institutional Review Board
6. deaths that are subject to but waived by the coroner's office such as
 - children who are dead on arrival to the hospital
 - deaths occurring within twenty-four hours of admission
 - deaths in which the child sustained or apparently sustained an injury while hospitalized
7. deaths where it is believed that autopsy might disclose a known or suspected illness that might have a bearing on survivors, recipients of organ transplants or subsequently family members
8. deaths that are known or suspected to have resulted from environmental or occupational hazards

No autopsy shall be performed without the written consent of the legally authorized agent. All DCH autopsies shall be performed by the DCH pathologist or by a physician delegated this responsibility. The attending physician shall be notified of the intent to begin an autopsy (or the scheduled time of the procedure). Copies of the final autopsy report shall be forwarded to the patient's attending physician and the medical record. Further information is available in the policies of Dayton Children's Hospital.

CONDUCT

Unprofessional and unethical conduct and the violation of these rules and regulations, or those of the hospital, shall constitute cause for withdrawal of privileges from this hospital (Professional Staff Bylaws).

CONSULTATION

A. General: The responsibility for patient care rests with the physician or dentist, but consultation is required as set forth below. The purpose of the consultation request shall be indicated in writing on the appropriate form and processed in the usual manner. The practitioner accepting the consult shall respond by attending the patient within a period of time consistent with the medical needs of the patient. When the consultation concerns an urgent or acute problem, it is recommended that the referring physician make an attempt to personally contact the consultant.

B. Required Consultations:

1. Consultation shall be required in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient is incompetent.
2. Consultations are encouraged in all cases in which, in the judgment of the attending physician:
 - a) the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - b) there is doubt as to the best therapeutic measures to be used;
 - c) unusually complicated situations are present that may require specific skills of other practitioners;
 - d) the patient exhibits severe symptoms of mental illness or psychosis; or
 - e) the patient is not a good medical or surgical risk.

Additional requirements for consultation may be established by the professional staff as required.

C. Qualifications: The consultant must be well qualified to give an opinion in the field in which his opinion is sought. Major staff privileges in the field concerned is the usual accepted evidence of qualification.

D. The Consultation: A satisfactory consultation includes examination of the new patient, review of the chart, and a written or dictated report of findings and recommendations signed by the consultant and made a part of the record. When the primary consultation note is dictated, it is essential that the initial recommendations should be included in a written note in the record, to provide immediate advice while the dictated note is transcribed. Direct conversation between the consulting physician and the requesting physician and/or resident caring for the patient is also encouraged. Follow-up notes to the original consultation can be dictated or written. If dictated and if there are substantive recommendations that could affect the management of the patient, a brief written note is also required. Consultations should be completed within a time frame that is consistent with the medical needs of the patient. Urgent/emergent consults are best accomplished when the requesting physician contacts the consultant directly. Presurgical consultation reports, at least in brief form, shall be recorded prior to the operation.

E. Administrative Request for Consultation: In circumstances of grave urgency, or when there is a disagreement regarding treatment, or when consultation is required by rules of the hospital, the Vice President for Medical Affairs shall at all times have the right to call in a consultant after conference with the Chairman of the Professional Staff or an available member of the Executive Committee. An earnest attempt should be made to notify the attending physician before obtaining consultation.

DISCHARGE

A. Discharge Planning: Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including as assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine no discharge planning is necessary in a particular case, that conclusion shall be noted on the medical record of the patient.

Discharge planning shall include, but need not be limited to the following:

- a) appropriate referral and transfer plans;
- b) methods to facilitate the provision of follow-up care; and
- c) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, and the amount of activity the patient should engage in and any necessary medical regimes including drugs, diet, or other forms of therapy. Sources of additional help from other agencies and procedures to follow in case of complications should also be a part of the discharge plan. All such information should be provided by the attending physician.

B. Patients shall be discharged only upon the approval of the attending physician or dentist. Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of a parent, legal guardian, or another responsible party as defined in the DCH policy, entitled Discharge When Parent/Legal Guardian are not Available. At the time of discharge, the final diagnosis must be recorded on the face sheet, progress notes, or order sheet before the patient may leave the hospital. Should a patient leave the hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient shall be asked to sign the hospital's release form.

PROFESSIONAL STAFF DISASTER ASSIGNMENTS

All physicians and dentists shall be assigned to posts either in the hospital, or in other area hospitals, or in mobile casualty stations, and it is their responsibility to report to their assigned stations. In the event of a major disaster, all physicians and dentists on the Professional Staff of the hospital specifically agree to relinquish direction of the professional care of their patients, service and private, to the Head of the Disaster Emergency Medical and Surgical Services.

ORDERS AND DRUGS

A. Patients: All patients must have written orders upon admission.

B. Written Orders: All orders for diagnostic procedures, treatments or medications shall be in writing. All prescriptions or medication orders shall be reviewed by the pharmacist and verified and the patients identified prior to administering the medication. In cases when the medication order is written and the pharmacist is temporarily unavailable the medication order shall be reviewed by the pharmacist as soon thereafter as possible.

C. Verbal/telephone/fax orders: Verbal/telephone/fax orders (V.O./T.O./F.O.) dictated by a member of Dayton Children's Hospital Professional Staff or his/her designee must be accepted by an individual possessing the appropriate clinical privilege related to the order and shall then be considered to be in writing. The order must relate to the clinical area in which that person is a practitioner. Such persons include registered nurses, respiratory therapists, licensed radiology personnel, occupational therapists, dietitians, laboratory personnel or members of the allied health staff. The Professional Staff acknowledges that verbal orders should be used very selectively. Widespread use of verbal orders is to be discouraged. Verbal orders should be acknowledged and signed by the authorizing provider or his/her designee as soon as possible. Unsigned verbal orders become delinquent at 28 days.

- Only RNs and pharmacists may accept medication orders.
- Respiratory therapists may receive medication orders related to respiratory therapy.
- Radiology Technicians may receive medication orders related to a radiologic procedure (i.e. use of Contrast).
- The person accepting the verbal or telephone order, must also write/enter the order and read back the order to the practitioner.
- The order is transcribed with the date and time of order on the order sheet and person relaying the order, documentation should include V.O./T.O./F.O., the practitioner's name and the authorized recipient's name/signature.
- In an emergency situation, a verbal or telephone order need only be repeated back to the practitioner (i.e. when a code is in progress, the order can be written at a later time).

D. Standing Order: Standing orders shall be submitted by a member of the Professional Staff, for review through the respective divisions and departments of Medicine and/or Surgery. All proposed or revised standing orders shall require approval, re-approval or acceptance of revisions by the respective Departments of Medicine and/or Surgery; and pharmacy when appropriate. Standing orders may not replace or conceal those written for specific patients. These orders must be signed by a licensed independent practitioner. Existing Standing Orders shall be reviewed as needed by the Departments of Medicine and/or Surgery.

E. Stop Orders: All drugs in the categories listed below, ordered for patients in the hospital without specific limitation as to dosage and time, shall be called to the attention of the attending physician or dentist upon expiration dates as designated below.

Narcotics – Schedule II.....7days

Antibiotics – if physician does not state length of therapy.....7days

F. Unusual Orders: When a nurse, pharmacist, radiology technician or respiratory therapist receives a medication order in unusual circumstances or in dosage out of therapeutic range (as documented in appropriate current literature or as recommended by the Pharmacy and Therapeutic Committee), this person must verify the order with the physician or dentist. If the nurse, pharmacist, radiology technician or respiratory therapist is still uncomfortable after receiving verification, she/he may consult with the Division or Department Head involved to resolve the issue. If the issue is not resolved, and the nurse, pharmacist, radiology technician or respiratory therapist is uncomfortable implementing the order, the order should be

referred to Nursing Administration for review and resolution. If the situation cannot be resolved, the Vice President for Hospital Operations and the Vice President for Medical Affairs will collaborate until the issue is resolved.

G. Drugs: Drugs used shall be those listed in the United States Pharmacopoeia, National Formulary, New and Non Official Remedies, or which have been approved by the Food and Drug Administration. Investigative use of unlisted drugs must be approved by the Institutional Review Board (IRB). When appropriate, the empiric utilization of certain antibiotics will be restricted.

H. Non-Member Practitioners: Physicians, Psychologists and Dentists who are not members of Dayton Children's Hospital Professional Staff, but have a documented, appropriate, current license from any state may order Dayton Children's Hospital Ancillary Services for their ambulatory patients.

I. Medication Errors: Adverse Reactions: Any medication error or apparent drug reaction shall be reported immediately to the physician who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record. Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity and to prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the physician and to the director of pharmaceutical services. Significant adverse reactions shall also be reported promptly to the Food and Drug Administration (FDA) and to the drug manufacturer as required.

J. Medical Errors : A medical error is defined as an unintended act, either of omission or commission, or an act that does not achieve its intended outcome. Professional staff members are committed to:

- 1) Creating a culture of safety at DCH
- 2) Encouraging open discussion and study of medical errors
- 3) Encouraging internal reporting of errors
- 4) Engaging staff in the design of system change to prevent recurrence of errors
- 5) Establishing mechanisms aimed at prevention of medical errors by prospective analysis of vulnerable system
- 6) Communicating, in an appropriate manner, of occurrence of errors to patients/parents/guardians (see policy on disclosure of errors)

RECORDS

A. General: A medical record shall be maintained for each patient who is evaluated or treated as an inpatient, ambulatory care patient, or emergency patient. The provider documents any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia in the patient's medical record. A high risk procedure is any procedure that is known to expose a patient to the possibility of permanent loss of a bodily function or significant injury. Generally, this includes procedures requiring a signed consent.

B. Authentication: All entries in the record must be legible, complete, timed, dated and authenticated by the signature of the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry may be individually authenticated by the signature of the individual making the entry, signature stamps or signature by a computerized system after the dictated report is reviewed by the author.

C. Contents: A complete medical record shall include:

- 1) identification data, including the patient's name, address, the date of birth, the next of kin, as well as, as single unit number that identifies the patient and the patient's medical record;
- 2) the date of admission and discharge;
- 3) the medical history, including: the chief complaint, details of the present illness, including when appropriate, assessment of the patient's emotional, behavioral, social, functional and nutritional status, relevant past social and family histories, menstrual and obstetrical history in females, an inventory by body systems, and drug sensitivities/allergic history;
- 4) provisional admitting diagnosis;
- 5) report of a physical examination, including but not limited to vital signs, head, chest, abdomen and extremities, or a note as to the contra-indications for such an examination or valid reasons why the examination was not performed. The physician's assessment shall be completed within twenty-four (24) hours of admission to the inpatient service;
- 6) a statement of the conclusions or impressions drawn from the admission history and physical examination;
- 7) diagnostic and therapeutic orders;
- 8) evidence of appropriate informed consent;
- 9) family's or legal representative's expectations for, and involvement in, the assessment, treatment and/or continuous care of a minor or otherwise incompetent patient;
- 10) clinical observations, progress notes, nursing notes, consultation reports;
- 11) reports of procedures, tests and the results, including operative reports;
- 12) reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures; and
- 13) conclusions at termination of hospitalization, including the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses, the clinical resume or final progress note, and, when appropriate, the autopsy report.

D. Non-medical Comments: Unjustifiable criticism or personal attacks against physicians, dentists, hospital personnel or the hospital itself, shall not appear in the medical record. Any questionable violation of this rule shall be referred for review and possible action, or governed by the Code of Conduct Policy.

E. History and Physical: A medical history and physical examination (H&P) must be completed no more than 30 days before or 24 hours after admission for each patient by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. Other qualified licensed practitioners could include nurse practitioners and physician assistants. The H&P must be placed in the medical record within 24 hours after admission. If the H&P is dictated, a short holding note will be placed in the chart within 24 hours. When a previously completed H&P is utilized, an updated medical record entry documenting an examination for any changes in the patient's current condition is completed. (Note: For patients with no changes, the update may state that the H&P was reviewed, the patient examined, and the physician concurs with the finding of the H&P performed on "X" date. If there

are changes, the update will state that the H&P was reviewed and the patient examined, and the physician concurs with the previous H&P with the following additional changes or exceptions.)

The history and physical examination records are the responsibility of the attending physician, and, if they are written by a member of the house staff, they shall be verified and signed by the attending physician in addition to being signed by the individual preparing the record.

F. Preoperative Record: The patient's medical history and physical examination are recorded in the medical record before an operative or other such history and physical examination must be recorded before the time stated for the operation or a procedure requiring anesthesia services. In an emergency, an acceptable history and physical for preoperative purposes may be limited to major significant conditions requiring immediate surgery. If the history and physical examination have been dictated and not transcribed on the chart, they shall be regarded as to having been recorded on the chart, except that a brief note to the effect and a sufficient clinical summary shall be written to justify surgery and to inform ancillary personnel. Confirmation of discussion about risks, benefits and options between the patient and the practitioner for operative and invasive procedures, including blood transfusions, should be documented in the admitting note, the progress notes, the consultation note, a duly executed informed consent form, and/or an operative/procedural consent form.

A properly executed written consent by the legal guardian of the patient is required for general anesthesia and any operative procedure upon any patient at Dayton Children's Hospital.

G. Surgical Record:

1. Except in emergencies, the following data as appropriate shall be recorded in the patient's medical record prior to surgery, or the operation shall be automatically cancelled:
 - a) verification of patient identity;
 - b) medical history and supplemental information regarding drug sensitivities and other pertinent medical facts;
 - c) general physical examination results, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;
 - d) provisional diagnosis;
 - e) laboratory test results;
 - f) consultation reports;
 - g) consent form signed by the surgeon and the patient or the patient's legal representative, and an anesthesia consent form signed by the patient or the patient's legal representative and the attending anesthesiologist; a current hospital consent form, if applicable, signed by the patient or his/her representative.
 - h) radiology reports, if applicable; and
 - i) other ancillary reports, if applicable.
2. Except in the case of an emergency, the patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received.
3. A detailed operative report shall be dictated within twenty-four (24) hours following surgery, and the completed operative report shall be authenticated by the surgeon and filed in the patient's medical record as soon as possible thereafter.
4. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. The exception to this requirement occurs when a brief operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital (see "J. Completion of Records"). This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. If the practitioner performing the

operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

5. The operative or other high risk procedure report includes, but is not limited to, the following:
- The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
 - The name of the procedure performed
 - A description of the procedure
 - Findings of the procedure
 - Any estimated blood loss
 - Any specimen(s) removed
 - The postoperative diagnosis

All tissues removed in the operating room and sent to the hospital pathologist shall be examined as the pathologist considers appropriate to arrive at a pathological diagnosis. He/she shall issue a signed report which shall become a permanent part of the patient's record.

H. Post Operative/Anesthesia Evaluation: The patient is initially evaluated on arrival to the PACU and this evaluation will include vital signs and level of consciousness. Report will be given to the PACU RN as to medication and fluids administered in the OR and any intraoperative complication or concern. The second post anesthesia evaluation shall be conducted either upon transfer from the post-anesthesia recovery area to the floor, discharge home, or within 48 hours of the anesthetic and shall be documented in the patient's chart by an anesthesiologist or nurse anesthetist. The post anesthetic evaluation note will include a review of the patient's vital signs, level of consciousness, respiratory function, cardiovascular function, temperature, pain, nausea/vomiting and postoperative hydration. Any unusual events or postoperative complications and management of those events should be documented in the post anesthesia evaluation note prior to the patient's discharge from the PACU. For patient admitted to the hospital postoperatively, further post-anesthesia visits shall be determined by the status of the patient in relation to the procedure performed and anesthesia administered. Upon notification by the surgical or nursing staff of any apparent post-anesthetic complication or problem occurring following discharge from the PACU, the responsible anesthesiologist or a qualified anesthesia care provider as his/her designee, will evaluate the patient and record the appropriate findings, recommendations and plan for follow-up care in the medical record.

The medical record must contain the following postoperative information:

- The patient's vital signs and level of consciousness
- Any medications, including intravenous fluids and any administered blood, blood products, and blood components
- Any unanticipated events or complication (including blood transfusion reactions) and the management of those events.

The medical record must contain documentation that the patient was discharged from the post-sedation or postanesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria.

I. Discharge Summary: The medical record must contain documentation of the use of approved discharge criteria that determine the patient's readiness for discharge. The discharge summary or clinical resume should include the following seven elements: (1) reason for hospitalization, (2) significant findings, (3) hospital course (4) procedures performed and treatment rendered, (5) condition of the patient on discharge, and (6) any specific instructions given to the patient and/or family relating to physical activity, medication, diet and follow-up care, (7) the name of the licensed independent practitioner responsible for the discharge.

A discharge summary is required for every inpatient admission to Dayton Children's Hospital. This can be either in electronic health record or dictated discharge summary format. For any admission longer than four days, a systems-based format is indicated.

J. Completion of Records: The requirements for the completion of records are:

1. Records should be completed within thirty (30) days. Records more than 30 days old are considered delinquent.
2. Final notice of Pending relinquishment of admitting privileges will automatically be sent to all physicians and dentists who have delinquent records. This notice will identify which records are delinquent.

Physicians and dentists are responsible for advising the Medical Records Administrator of extenuating circumstances (illness, vacation, etc.) to excuse them from completing their medical records within the thirty (30) day period.

Relinquishment of admitting privileges does not in any way affect the physician's or dentist's responsibilities for patients already under their care in the hospital.

3. Physicians and dentists who have admitting privileges relinquished twice during a reappointment period and who again become delinquent, are deemed to have voluntarily resigned from professional staff membership. The physicians, dentists or psychologists will have to reapply for staff privileges after completion of their medical records. When a member's privileges are automatically relinquished, they will be unable to admit patients to the hospital or schedule surgery until reapplication in writing has been approved by the appropriate committees.

K. Ownership: All medical records are the property of the hospital and may not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending physician or dentist whether the patient is being attended by the same physician or dentist or another.

L. Access to Records: Free access to all medical records of all patients shall be afforded to the staff physicians and dentists in good standing for bona fide study and research consistent with the preserving of confidentiality of personal information concerning individual patients. Subject to the discretion of the President/Chief Executive Officer, former members of the Professional Staff shall be permitted free access to information from the medical records of their patients covering all periods in which they attended such patients in the hospital.

M. Dental Records: In addition to all the other sections of the Rules and Regulations related to the directives and procedures for patient care, dentist members of the attending staff shall be responsible for generating and completing a clinical record for each dental patient. These records on dental admissions and dental consultations shall be included as part of the patient's medical record and they shall contain, among other things the following entries:

- a. In addition to the medical history requires by Paragraph I-J, a dental history justifying the hospital admission.
- b. The results of an examination of the oral cavity and preoperative diagnoses.
- c. A dictated operative report that describes and documents the oral findings and all operative procedures.
- d. Preoperative and postoperative orders, progress notes, and a dictated discharge summary.

N. Release of Information: Upon written authorization of the patient or legally authorized representative, the Medical Records Department shall transmit information to other hospitals or health care facilities requesting data concerning the patient's previous admissions, record name, birth date and dates of previous hospitalization.

QUALITY REVIEW

Following the expiration of a patient, a quality review of the patient's case will be accomplished by the respective oversight committee (i.e. NICU QA, ED QI, Trauma QI, etc.). A Mortality Review Worksheet will be accomplished by the attending physician and forwarded within 90 days of the death of the patient to the Children's Quality Improvement Committee (CQIC). The committee will review the listed cause of death, the evaluation/narrative (to include history and treatment), review of care, follow up measures, whether the death was medically preventable and any contributing factors which influenced the patient's condition. CQIC will then either close the review or request further information by the attending physician and/or oversight committee.

RESIDENT FUNCTIONS

Pediatric residents and residents from other disciplines who rotate at Dayton Children's Hospital, are expected to perform admission histories, physical examinations, and develop an initial differential diagnosis, plan of treatment and write appropriate orders on patients admitted to their service. In these activities, the resident will be supervised by the private/staff attending physician or dentist. When appropriate and before writing orders, the resident is expected to communicate with the attending physician who is responsible for the patient.

During the course of the patient's hospitalization, the resident is expected to write daily progress notes concerning the patient's hospital course and to communicate daily with the attending physician. During the patient's hospitalization, when changes in treatment plan or in diagnosis are considered, the resident is expected to communicate with the attending physician and to write a note in the hospital record. When any significant change in the patient's condition or orders are contemplated, the resident should notify the attending of the change in condition and/or of the contemplated change in orders and then document the nature of the change in condition and other pertinent information in the medical record. These changes include (but are not limited to): changes in the patient's status, changes in the patient's location within the hospital, and particularly whether or not the patient is to be discharged. Decisions concerning patient care management, including responsibility for writing and/or approving orders, rests ultimately with the private/staff attending physician or dentist. However, it is desirable in a teaching setting that such decisions are made together with the resident staff.

In emergency situations, the house officer should respond immediately to correct the acute emergency needs of the patient. As soon as possible, the attending physician is to be notified by the resident of the condition of his or her patient.

The supervising attending physician is required to countersign the admitting history and physical examination of all residents and to document daily his supervision of the resident in the treatment plan and daily progress of the patient. Any statement made in the medical record by a resident may be changed by the attending physician and initialed.

INFECTION CONTROL

All nursing units shall follow the standard procedure for isolation as outlined in the Infection Control Manual which is based on the Centers for Disease Control's Guidelines for Isolation Precautions in Hospitals (CDC Guidelines).

Any patient with a known or suspected communicable disease or infection shall be isolated as required by the Infection Control Manual. The attending physician will be notified. The Chairman of the Infection Control Committee shall be empowered to order appropriate isolation procedures or epidemiologic investigations as required. Cultures of draining wounds and stool cultures on patient with unexplained diarrhea may be requested by a department chairman in consultation with the Chairman of the Infection Control Committee or the Infection Control Registered Nurse. Attending physicians, residents, employees and other health care personnel with infections shall comply with applicable infection control policies and procedures. When a series of infections, including postoperative infections, occurs, the Chairman of the Infection Control Committee shall initiate procedures necessary to investigate and prevent further spread of infection.

AMENDMENTS

The professional staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws. Amendments to the professional staff rules and regulations may be introduced by any member of the active professional staff, or committee of the professional staff. Particular rules and regulations may be adopted, amended, repealed or added by vote of the executive committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the professional staff bulletin board and the DCH website (or equivalent) at least fourteen (14) days prior to the next executive committee meeting. Upon written request by a professional staff member to the professional staff office, a copy of the proposed changes to the rules and regulations will be mailed to the requesting professional staff member. All written comments on the proposed changes by individuals holding current appointments to the professional staff must be brought to the attention of the executive committee before the changes are voted upon. If the active professional staff disagrees with the changes and/or amendments, a special meeting of the active professional staff may be called to hear concerns by petition of 10% of the active professional staff to the executive committee. A minimum of 20% of the active professional staff must attend the special meeting. Two-thirds of the active professional staff present at the meeting must vote to overturn the proposed amendment. The overturned amendment will then be forwarded back to the executive committee for reconsideration. If 20% of the active professional staff are not present at the special meeting, the proposed amendment as voted on previously by the executive committee will then be final.

These rules and regulations shall be adopted at any regular meeting of the professional staff executive committee and shall become effective when approved by the board of trustees. Neither the professional staff nor the board of trustees may unilaterally amend these rules and regulations. A current copy of the professional staff rules and regulations will be maintained on the DCH website. Any professional staff member may request a copy of these rules and regulations by submitting a written request to the professional staff office. Significant changes to these rules and regulations (as determined by the professional staff executive committee) shall be cause to notify all professional staff members that such changes have occurred. Revised texts of the changes will be made to professional staff members.