

Medical Staff Onboarding and Annual Education



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Purpose and Applicability

This education provides consistent onboarding and annual education for UTMHC medical staff and credentialed practitioners.

The education addresses UTMHC's core expectations for patient safety, quality of care, patient rights, professional conduct, privacy, infection prevention, emergency response, documentation, and regulatory compliance.

All practitioners are expected to understand the requirements that apply to medical staff practice at UTMHC. Some responsibilities apply when the practitioner holds specific privileges, participates in a particular service, provides on-call coverage, or performs designated clinical duties.

Additional education and competency requirements: Completion of this core medical staff education does not replace training or demonstrated competency required for a provider's assigned duties or privileges. UTMHC assigns and documents applicable education and competency for activities such as restraint or seclusion, suicide-risk assessment, waived testing, transplantable tissue use, emergency response, sedation, and radiology. Providers must complete the applicable requirements before performing the activity and thereafter at the interval required by the governing standard and UTMHC policy.

Key point: This education provides core medical staff expectations. Practitioners are also responsible for completing any role-specific, privilege-specific, department-specific, or program-specific education required by UTMHC.



Education Required for Your Role

Core medical staff education applies to all credentialed practitioners. Additional education depends on your privileges, assigned duties, and practice setting.

- Complete this core education and attestation as assigned.
- Complete separate training and competency validation before performing duties that require them, including applicable restraint or seclusion responsibilities, suicide-risk assessment, point-of-care testing, transplantable tissue use, sedation, and imaging.
- Complete department-specific emergency response and on-call education when those duties are assigned.
- Check your assigned education requirements with the Medical Staff Office and the department responsible for the activity.

Key point: Completing this deck acknowledges core expectations. It does not grant privileges or replace required test-specific or procedure-specific competency.



Completion Instructions

Medical staff and credentialed practitioners must review this education in full and understand the responsibilities that apply to their practice at UTMC.

Completion requirements:

- Review each section.
- Follow applicable UTMC policies, Medical Staff Bylaws, Rules and Regulations, and department/service expectations.
- Apply requirements that relate to your clinical privileges, assigned duties, on-call responsibilities, and patient care activities.
- Complete the acknowledgment, or post-test assigned by the Medical Staff Office.
- Complete separate sedation, radiology, or other privilege-specific education when assigned.
- Contact the Medical Staff Office or the appropriate UTMC department when clarification is needed.

Key point: Completion of this education does not replace the practitioner's responsibility to know and follow applicable policies, privileges, laws, regulations, and clinical standards.



Attestation Expectation

Completion documents that the practitioner reviewed UTMHC's core medical staff expectations and understands the requirements applicable to the practitioner's privileges, assigned duties, and patient care responsibilities.

By completing the attestation, the practitioner confirms understanding of their responsibility to:

- Provide safe, ethical, respectful, nondiscriminatory, and patient-centered care.
- Practice within approved clinical privileges, scope, licensure, training, and competency.
- Protect patient privacy and confidential information.
- Document accurately, timely, and completely.
- Follow UTMHC policies, Medical Staff Bylaws, Rules and Regulations, and applicable regulatory requirements.
- Report patient safety, quality, compliance, privacy, professional conduct, impairment, abuse/neglect, workplace violence, and regulatory concerns through the appropriate process.
- Complete additional required education based on role, privileges, specialty, practice setting, or assigned program participation.

Key point: The attestation documents review and acknowledgment of core expectations for medical staff practice at UTMHC. Completion of this education does not independently grant clinical privileges or validate competency for a procedure, service, or specialized responsibility.



Medical Staff Professional Foundations

University of Toledo Medical Center Mission

The mission of The University of Toledo Medical Center is to improve the human condition by providing patient-centered, university-quality care.



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University of Toledo Medical Center Core Values

Respect: We treat all individuals and groups equitably as we demonstrate high standards of behavior, communication and interactions with others. We also respect ourselves by ensuring that our performance delivers value and is reliable and of high quality.

Ownership: We provide excellence and work with a sense of urgency in the delivery of our services and in owning our errors, as well as correcting any lapses.

Commitment: We make and meet commitments by doing what is right for the success of the University's mission and communicating well with those we serve. We define success in this endeavor by doing the right things and doing them well.

Knowledgeable: We are committed to lifelong learning, which is essential to be the content providers and thought leaders in our areas of expertise. As part of our commitment, we cultivate and maintain talent form within by providing training and development opportunities

Ethical: We demonstrate personal integrity, honesty and ethical behavior, which are integral to our success.

Trusting: We create and foster an atmosphere of transparency and trust among those we serve and each other.

Medical Staff Professionalism

UTMC medical staff demonstrate professionalism through clinical judgment, respectful conduct, and accountability for patient care.

- Practice within approved privileges and seek assistance when a patient's needs exceed your expertise.
- Supervise learners according to their assigned responsibilities and applicable medical staff requirements.
- Listen when a patient or team member raises a concern. Address a safety question before proceeding.
- Communicate disagreements respectfully and escalate unresolved concerns through the appropriate clinical process.

Key point: Professionalism is shown in how physicians make decisions, supervise care, and respond when someone speaks up.



iCare in Patient Communication

Patients should understand their condition, the recommended plan, and what happens next.

- Introduce yourself and explain your role.
- Discuss the diagnosis, treatment options, material risks, and reasonable alternatives in language the patient can understand.
- Use a qualified interpreter or communication aid when needed, and check understanding for important decisions or instructions.
- Respond to pain, distress, questions, and changes in condition with assessment and follow-through.

Key point: Clear explanations and a clinical response to concerns are part of patient-centered care.



Confirm the Correct Patient

Confirm patient identity before providing care or acting on a patient-specific order.

- Use at least two patient identifiers (i.e. patient name, date of birth) and compare them with the order, record, specimen label, or planned treatment.
- Actively confirm identity before a procedure, specimen collection, medication or blood administration, or other patient-specific treatment.
- Do not use a room number or location as an identifier.
- If information does not match, pause and resolve the discrepancy before proceeding.
- Ensure specimens and procedure documentation are linked to the correct patient.

Key point: Correct treatment depends on identifying the correct patient at the point of care.



Coordination and Follow-Through

A safe plan identifies what remains to be done and who is responsible.

- Communicate changes in condition, unresolved problems, pending tests, and monitoring needs during handoffs.
- Identify who will review results and act on follow-up needs after transfer or discharge.
- Explain medication changes, warning signs, and follow-up plans to the patient or caregiver.
- Document decisions and communications needed by the next care team.

Key point: The patient and the next provider should know the plan, the next step, and who owns it.



Scope of Practice, Privileges and Practitioner Accountability

Medical staff and credentialed practitioners may only provide care, perform procedures, order services, supervise care, or participate in clinical activities that are consistent with their approved clinical privileges, licensure, credentials, training, competency, UPMC policy, and applicable law.

Medical staff expectations:

- Know and follow your approved clinical privileges.
- Do not perform procedures, services, or clinical activities outside your granted privileges.
- Request additional privileges before performing a new procedure, service, or clinical activity that is not currently approved.
- Follow supervision, collaboration, and delegation requirements for residents, fellows, students, APPs, and other team members.
- Escalate questions about scope, privileges, supervision, or competency before care is provided.
- Report concerns when a practitioner may be practicing outside approved scope, privileges, competency, or policy.

Key point: Safe care requires every practitioner to practice within approved privileges, licensure, training, competency, and UPMC policy.



Professional Conduct and Disruptive Behavior

UTMC medical staff are expected to communicate and behave in a professional, respectful, and collaborative manner that supports patient safety, quality of care, and an effective care environment.

Disruptive behavior includes conduct that interferes with patient care, team communication, staff safety, or the ability of others to carry out their responsibilities.

Examples may include:

- Verbal abuse, intimidation, threats, or humiliation
- Physical aggression or threatening gestures
- Sexual harassment or discriminatory conduct
- Retaliation against someone who raises a concern
- Refusal to communicate necessary clinical information
- Behavior that undermines teamwork, delays care, or creates fear of speaking up

Disruptive conduct by medical staff is not tolerated and should be reported through the appropriate process, including the Chief Medical Officer or designee, Medical Staff leadership, Human Resources, Compliance, or other leadership pathway when applicable.

Refer to the Medical Staff Bylaws, Rules and Regulations, Code of Conduct, and applicable UTMC policy for additional requirements.

Key point: Professional conduct is a patient safety expectation. Concerns should be reported early so they can be addressed through the appropriate medical staff or organizational process.

[Professionalism and Prohibited Disruptive Behavior Regarding Members of the Medical Staff](#)



Compliance, Privacy, Reporting, and Quality Accountability



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HIPAA Medical Staff Responsibilities

HIPAA protects a patient's right to privacy and requires UPMC medical staff and credentialed practitioners to safeguard protected health information.

Protected health information may include information in Epic, paper records, conversations, emails, text messages, photographs, printed materials, and any other patient-identifiable information.

Medical staff expectations:

- Access patient information only when needed for treatment, payment, healthcare operations, or another permitted purpose.
- Use only the minimum necessary information when sharing PHI, unless the disclosure is for treatment.
- Do not access records for curiosity, personal reasons, family members, coworkers, VIPs, public figures, or patients not under your care.
- Use approved UPMC systems and processes when accessing, communicating, documenting, printing, or storing patient information.

Key point: Access to patient information must be based on a legitimate clinical or business need, not availability in Epic or personal interest.

[Security and Protection of Patient Information Both Paper and Electronic](#)
[Minimum Necessary Guidelines for Use/Disclosure of Protected Health Information](#)

HIPAA Risk Areas and Reporting

Medical staff are responsible for protecting patient information in all forms and settings.

Common HIPAA risk areas include:

- Discussing patient information in public or semi-public areas.
- Sending PHI to the wrong recipient.
- Texting, emailing, photographing, printing, or storing PHI outside approved UTMC processes.
- Leaving patient information visible on screens, printers, desks, workstations, mobile devices, or in procedure areas.
- Accessing records of family members, coworkers, VIPs, public figures, or patients not involved in your care.
- Using personal devices or unapproved applications to capture, transmit, or store patient information.

Suspected privacy or security incidents must be reported promptly. Examples include misdirected messages, lost or stolen devices, inappropriate access, unauthorized disclosure, or suspected compromise of login credentials.

When unsure, pause and contact the Privacy Office, Compliance, Medical Staff Office, or Health Information Management before disclosing PHI.

Key point: Protect patient information the same way you would expect your own health information to be protected.



Speak Up and Escalate

When you identify a concern that could affect patient safety or quality of care:

- Address any immediate risk to the patient.
- Tell the responsible clinician and appropriate clinical leader what you observed.
- Escalate promptly if the concern is serious, unresolved, or outside your authority to correct.
- Use the reporting pathway that applies to the concern, including Patient Safety Net, Medical Staff leadership, Quality and Patient Safety, Risk Management, or Compliance.

Medical staff may also report patient safety concerns directly to The Joint Commission or the Ohio Department of Health. An internal report is not a prerequisite for external reporting.

Key point: Protect the patient first, then make sure the concern reaches someone who can act.

Immediate Response to a Patient Safety Event

When a safety event occurs or is discovered:

- Assess the patient and provide needed care.
- Notify the attending physician and the appropriate clinical leader.
- If equipment or a device may be involved, remove it from use and arrange for it to be secured.
- Immediately report the event to the manager or immediate supervisor. Escalate a potentially serious event without waiting for a written report.
- Document the patient's condition, care, notifications, and relevant communication in the medical record.

For a serious event, coordinate communication with the patient or family through UTMC's event response process. Do not place or refer to the Patient Safety Net report in the medical record.

Key point: The event report supports review; the medical record tells the clinical story.



Patient Safety Net and Just Culture

Report patient safety events, near misses, and unsafe conditions, including events that did not harm a patient.

- Notify the manager or immediate supervisor immediately when you become aware of a safety event.
- You or the manager/supervisor must enter the event in Patient Safety Net within 24 hours of the event or learning of it.
- Provide factual information and participate in follow-up review when requested.
- UTMC's Just Culture process examines system factors and individual decisions to support fair accountability and prevent recurrence.

Key point: Report early and accurately. The 24-hour entry window does not delay immediate clinical notification or escalation.

Compliance and Professional Concerns

Report concerns about care or conduct that may put patients, UTMC, or federal healthcare programs at risk. Examples include:

- Unsafe practice, suspected impairment, or conduct that interferes with patient care.
- Inaccurate documentation, unsupported billing, or medically unnecessary services.
- Improper referrals or inducements, conflicts of interest, or controlled-substance concerns.
- Privacy breaches, retaliation, or a change in licensure, sanctions, exclusions, or privileges that must be disclosed.

Use the appropriate pathway: department chair or service chief, Chief Medical Officer, Medical Staff Office, Compliance, Privacy, Risk Management, or Human Resources.

Address an immediate patient safety risk at once. Follow any separate external reporting duty that applies to you.

Key point: Give the right people the facts promptly so UTMC can protect patients and evaluate the concern.



Fraud, Waste, and Abuse: Provider Responsibilities

Clinical decisions, documentation, and referrals can affect patient care and the accuracy of claims.

- **Fraud:** Never document or attest to a service that was not performed or change the record to obtain payment.
- **Waste:** Order tests, treatments, and supplies based on the patient's clinical need; avoid unnecessary duplication.
- **Abuse:** Question billing, prescribing, or referral practices that could result in improper payment or unnecessary cost.
- Document the care provided and the clinical reason for it accurately. Disclose potential conflicts of interest and do not accept anything of value in exchange for referrals.
- Ask UPMC Healthcare Compliance when an arrangement or practice is unclear.
- Report a suspected concern through Healthcare Compliance or the Ethics and Compliance Hotline: 888-416-1308. Good-faith reports are protected from retaliation.

Key point: Provide clinically appropriate care, make the record accurate, and raise concerns before a questionable practice continues.



Medical Staff Participation in Quality, Peer Review, and Performance Improvement

UTMC's organized medical staff identifies education priorities based on the care provided, performance improvement findings, patient safety events, practitioner performance information, regulatory changes, and identified opportunities for improvement.

Medical staff members are expected to participate in applicable quality, peer review, professional practice evaluation, and performance improvement activities and incorporate identified improvements into practice.

Medical staff responsibilities may include:

- Participating in case review, peer review, OPPE, FPPE, quality review, or focused review processes.
- Responding to requests for documentation, clarification, or clinical review in a timely manner.
- Supporting corrective actions, action plans, education, or process changes when improvement opportunities are identified.
- Participating in medical staff committees, department review, service line quality activities, or hospital performance improvement efforts when applicable.
- Using event reports, near misses, patient complaints, adverse outcomes, and audit findings to improve care processes.
- Maintaining professionalism and confidentiality during peer review and quality activities.

Key point: Medical staff participation in peer review and performance improvement supports patient safety, quality of care, and regulatory compliance.



Safety, Security, and Emergency Preparedness



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Fall Prevention: Provider Actions

Address clinical factors that increase a patient's risk of falling.

- Consider changes in mental status, weakness, mobility, orthostasis, and the effects of opioids, sedatives, and other medications when making the treatment plan.
- Communicate new risks or changes in mobility to Nursing and the care team; update orders and the plan when needed.
- After a fall, promptly assess for injury and a possible medical cause. Order indicated evaluation and treatment, revise the prevention plan, and document the findings and response.
- Escalate and report the event through UTMHC's patient safety process. Serious injury requires immediate escalation under the applicable guideline.

Key point: A fall or change in fall risk calls for clinical reassessment, not simply a new risk score.



Hazard Communication/SDS/Spills

- Hazard Communication helps ensure that chemical hazards are identified, labeled, and communicated before use or exposure. Hazardous chemicals must be properly labeled, and Safety Data Sheets must be accessible to personnel working in the area.
- Medical staff and credentialed practitioners are expected to:
- Know how to access SDS information for chemicals used in their clinical or procedural area, including CHEMwatch or the approved department process.
- Do not use chemicals from unlabeled, damaged, or questionable containers.
- Use appropriate PPE and follow posted warnings, product labels, SDS guidance, and department procedures.
- If a chemical spill or exposure occurs, protect yourself and others, avoid spreading contamination, notify the appropriate department leader or response team, and follow UTMC spill/exposure procedures.
- Do not clean up a hazardous chemical spill unless trained, equipped, and authorized to do so.
- Education is provided at onboarding, when new chemical hazards or work processes are introduced, and as assigned by UTMC policy or annual safety education requirements.



Workplace Violence Prevention Medical Staff Responsibilities

UTMC is committed to maintaining a safe environment for patients, visitors, medical staff, employees, trainees, and volunteers.

Workplace violence may include physical assault, threats, intimidation, harassment, stalking, bullying, sexual harassment, aggressive behavior, or disruptive conduct.

Medical staff are expected to:

- Recognize early signs of escalating behavior.
- Use calm, respectful, non-threatening communication when safe to do so.
- Request help early when behavior is escalating or safety is uncertain.
- Follow UTMC's emergency response process when there is an immediate threat.
- Report workplace violence incidents, threats, harassment, assault, or near-miss events according to UTMC process.
- Support a culture where violence, intimidation, harassment, and disruptive conduct are not accepted.

Key point: Workplace violence prevention is a patient safety, workforce safety, and regulatory compliance priority.



Recognition and De-Escalation

Medical staff should be alert for behavior that may indicate increased risk for violence or escalation.

Warning signs may include:

- Raised voice, pacing, clenched fists, aggressive gestures, invading personal space, glaring, refusal to follow safety instructions, threats, fixation on a person or grievance, intoxication, confusion, delirium, paranoia, escalating family conflict, or possession of a weapon or object that could be used as a weapon.

When safe and clinically appropriate, medical staff should use basic de-escalation strategies:

- Use a calm tone and simple language.
- Introduce yourself and explain what you are doing.
- Listen without interrupting.
- Acknowledge the person's concern without agreeing to unsafe demands.
- Set clear, respectful limits.
- Offer choices when possible.
- Maintain a safe distance and keep access to an exit when possible.
- Ask for help early.
- Do not argue, shame, threaten, corner, physically block, or attempt hands-on intervention unless trained, authorized, and necessary to prevent immediate harm.

Key point: De-escalation should never place staff, medical staff, patients, or visitors at greater risk.



When to Call for Immediate Help

Medical staff should seek immediate assistance when there is a safety risk that cannot be managed through routine communication or clinical care.

Call for immediate help when there is:

- A direct threat to harm self or others.
- Physical assault or attempted assault.
- Weapon possession or suspected weapon possession.
- Property destruction.
- A person blocking exits or preventing staff from leaving.
- Escalating behavior that does not respond to verbal de-escalation.
- Unsafe visitor, family, or patient behavior.
- A credible threat toward staff, medical staff, patients, or others.
- Any situation where staff or medical staff feel unsafe.

Follow UTMC's emergency response process, including contacting Security and activating the appropriate emergency code or communication pathway according to policy.

Key point: Calling for help early is a safety action, not a failure to manage the situation.



Reporting and Post-Incident Expectation

All workplace violence incidents, threats, and near misses should be reported, even when no injury occurs.

Medical staff are expected to report:

- Threats, intimidation, harassment, stalking, or sexual harassment.
- Physical aggression, assault, attempted assault, or property destruction.
- Disruptive or threatening conduct by patients, visitors, staff, medical staff, or others.
- Near-miss events or situations where staff, patients, or visitors felt unsafe.

Calling Security, notifying a supervisor, or managing the immediate situation does not replace formal event reporting.

When patient care is involved, document relevant clinical facts in the medical record, including observed behavior, safety interventions, orders, patient response, notifications, and follow-up care.

Concerns involving medical staff or workforce conduct should be escalated through the appropriate medical staff, Human Resources, Compliance, Security, or leadership process.

Key point: Reporting helps UTMC identify trends, support affected individuals, improve prevention strategies, and maintain a safer care environment.



Emergency Management: Medical Staff Role

UTMC maintains an all-hazards Emergency Operations Plan to support patient care, safety, communication, and continuity of operations during emergencies.

Medical staff may be asked to assist with:

- Discharge decisions to create patient care capacity.
- Triage, secondary care areas, or specialty consultation.
- Medical direction for patient care areas.
- Support of surge, evacuation, shelter-in-place, or continuity-of-care needs.

During an emergency, medical staff should follow instructions from Incident Command, the Department Chair, the Chief Medical Officer, or assigned hospital leadership.

How UTMC Manages Emergencies

UTMC uses the Hospital Incident Command System to coordinate emergency response.

Emergency response may involve hospital leadership, medical staff leadership, nursing, security, facilities, environmental health and safety, communications, and external response partners.

Medical staff should use approved communication channels, follow emergency alerts, and avoid self-deployment to the ED, Command Center, or incident location unless directed.

Emergency Communication and Reporting Expectations

Medical staff are expected to:

- Know how emergency alerts are communicated at UTMC.
- Follow department-specific instructions during emergency codes.
- Report unsafe conditions, service interruptions, patient care concerns, or emerging hazards.
- Maintain patient care and documentation when safe and feasible.
- Direct media questions to the Public Information Officer/Office of Communications.
- Wear visible UTMC identification when onsite.



Medical Staff Response During Hospital Codes

Medical staff do not need to memorize every operational detail of each code but must understand their role when an emergency code is activated.

Key expectations:

- Protect patients, visitors, staff, and yourself from immediate harm.
- Follow Incident Command or department leadership direction.
- Respond to assigned staging or care areas when requested.
- Do not enter restricted or unsafe areas unless directed and safe to do so.
- Support patient movement, triage, treatment, discharge, or continuity of care based on specialty and assignment.



Mass Casualty / Surge Response

During a mass casualty or surge event, medical staff may be assigned to triage, treatment, consultation, discharge planning, procedural support, or specialty care areas.

Medical staff should report to the designated staging area or assigned location as directed.

Do not report directly to the ED or Command Center unless instructed.

Timely communication, role clarity, and coordinated patient flow are essential to maintaining safe care during surge conditions.



Security, Violence, Hazardous Events, and Evacuation

For violent situations, hazardous materials, bomb threats, severe weather, evacuation, or utility interruptions, medical staff should follow emergency alerts and department instructions.

If there is immediate danger, protect yourself and others when safe to do so, notify Security or emergency response resources, and follow Incident Command direction.

Do not attempt hazardous spill response, suspicious package handling, or security intervention unless trained, equipped, and directed.



Fire and Life Safety Response – R.A.C.E.

Any person who sees or suspects a fire should respond immediately using **R.A.C.E.**

Rescue

Remove anyone in immediate danger if it is safe to do so.

Alarm

Activate the nearest fire alarm pull station and notify the appropriate emergency response number according to UTMC policy.

Confine

Close doors and windows to help contain smoke and fire.

Extinguish or Evacuate

Use a fire extinguisher only if the fire is small, you are trained and able to do so safely, and you have a clear exit path. If the fire cannot be safely controlled, evacuate or relocate according to the emergency plan.

Medical staff and credentialed practitioners are expected to know the basic fire response process and follow department-specific procedures during a Code Red or fire-related event.

Key point: Protect life first, activate the alarm, contain the fire when possible, and follow the emergency response process.



Fire Extinguisher Use – P.A.S.S.

Use a fire extinguisher only when it is safe to do so, the fire is small, the correct extinguisher is available, and you have a clear exit path.

Follow **P.A.S.S.** when using a fire extinguisher:

- **Pull** the pin.
- **Aim** the nozzle at the base of the fire.
- **Squeeze** the handles together.
- **Sweep** from side to side until the fire is extinguished or until it is no longer safe to continue.

Medical staff expectations during a fire or Code Red:

- Follow department leadership, Incident Command, Security, Facilities, or fire official direction.
- Do not use elevators during a fire unless directed by fire officials or the emergency plan.
- Keep corridors, exits, fire doors, and medical gas shutoff valves clear.
- Assist with patient relocation, evacuation, triage, treatment, or discharge when assigned.
- Do not enter restricted, smoky, unsafe, or evacuated areas unless directed and safe to do so.

Key point: Do not attempt to fight a fire if doing so places you, patients, staff, or visitors at risk.



Evacuation, Relocation, and Life Safety Expectations

Medical staff should follow direction from Incident Command, department leadership, Security, Facilities, or fire officials during fire, smoke, evacuation, or life safety events.

Medical staff expectations:

- Protect patients, visitors, staff, and yourself from immediate harm.
- Do not use elevators during a fire unless directed by fire officials or the emergency plan.
- Keep corridors, exits, fire doors, and medical gas shutoff valves clear and accessible.
- Assist with patient relocation, evacuation, triage, treatment, or discharge when assigned.
- Do not enter restricted, smoky, unsafe, or evacuated areas unless directed and safe to do so.
- Direct media or public inquiries to the appropriate hospital communication pathway.



Medical Gas Awareness

Medical gas systems support oxygen, medical air, nitrous oxide, nitrogen, and vacuum systems in patient care areas. Shutoff valves may control gas supply to multiple rooms or patient care areas.

Medical staff expectations:

- Know that medical gas shutoff valves must remain accessible and clearly labeled.
- Do not block or store equipment in front of medical gas shutoff valves.
- Do not turn off medical gas valves on your own initiative.
- Medical gas should only be shut off during an emergency by authorized personnel or when directed through the emergency response process.
- Before any medical gas shutoff, patient impact must be considered whenever possible, including patients receiving oxygen, ventilation, anesthesia, procedural support, or other gas-dependent care.



Clinical Deterioration and Response



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Rapid Response – Provider Responsibilities

Call Rapid Response when an inpatient or patient in a covered ambulatory area shows acute deterioration or when a member of the care team is concerned about the patient's condition. Anyone on the healthcare team, and a family member, may initiate the call.

Activate the team: Call the operator at extension 7700 and give the patient's location.

Examples of triggers: Respiratory distress or threatened airway; significant change in consciousness; acute bleeding; new or prolonged seizures; systolic blood pressure below 90; heart rate below 40 or above 130; or serious concern despite vital signs that do not meet a listed threshold.

Provider response: Assess and treat the patient promptly, communicate with the Rapid Response Team, determine whether a higher level of care or Code Blue is needed, and document the assessment, interventions, response, and disposition. The treating or attending physician or designee must be contacted for an inpatient Rapid Response.

Key point: Do not wait for a specific vital-sign threshold if the patient is deteriorating. Activate the appropriate emergency response and continue care while help arrives.



Know the Patient's Code Status

Verify the current code-status order and discuss treatment goals when the patient's condition or wishes change.

- **Full Support:** Provide indicated treatment and resuscitation unless a valid order directs otherwise.
- **DNR Comfort Care (DNRCC):** The comfort-care protocol begins when the order takes effect.
- **DNR Comfort Care–Arrest (DNRCC–Arrest):** Provide appropriate treatment before arrest; the DNR protocol begins at cardiac or respiratory arrest.
- Ensure the order and relevant discussion are documented and communicated during handoff, transfer, and changes in condition.
- Before a procedure that could cause cardiopulmonary compromise, discuss whether and how the DNR order will apply during the procedure; document any agreed change according to UTMH policy.

Key point: DNRCC and DNRCC–Arrest have different treatment implications. Do not infer the patient's wishes from an old note or an undocumented conversation.



Rapid Response or Code Blue?

Choose the response based on the patient's condition and current code-status order.

Acute deterioration or serious concern; patient is not in arrest:

- Call Rapid Response: Dial 7700 and give the patient's location. Assess and treat the patient while the team responds

Apparent cardiac or respiratory arrest:

- Activate Code Blue immediately: Dial 7700 and give the patient's location. Begin resuscitation consistent with the patient's current code status and your assigned role.

After the response: Communicate the patient's condition and interventions to the receiving team, arrange the appropriate level of care, and document the response and disposition.

Key point: Do not wait for a vital-sign threshold when the patient is deteriorating. Apparent arrest requires an immediate Code Blue response.

Infection Prevention and Communicable Disease Safety



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Infection Prevention: Medical Staff Responsibilities

UTMC medical staff and credentialed practitioners play a direct role in preventing healthcare-associated infections and limiting transmission of communicable diseases.

Medical staff are expected to:

- Follow UTMC infection prevention policies and isolation precautions.
- Use standard precautions for every patient, every encounter.
- Perform hand hygiene reliably and model expected behavior.
- Use PPE based on anticipated exposure and posted isolation requirements.
- Follow safe injection, medication, and procedural practices.
- Support appropriate device use, timely removal of invasive devices, and prevention of CLABSI, CAUTI, SSI, C. difficile, and MDRO transmission.
- Prescribe antimicrobials responsibly and participate in antimicrobial stewardship.
- Contact Infection Prevention when guidance is needed for isolation, exposure, outbreak, communicable disease, or unusual infection concerns.

Key point: Infection prevention is part of everyday clinical care. Medical staff support compliance through reliable hand hygiene, appropriate PPE, safe procedures, responsible prescribing, and timely escalation of infection concerns.



Hand Hygiene and Standard Precautions

Standard precautions apply to all patients, regardless of diagnosis or known infection status.

Medical staff expectations:

- Perform hand hygiene before and after patient contact.
- Perform hand hygiene before aseptic tasks or invasive procedures.
- Perform hand hygiene after contact with blood, body fluids, mucous membranes, non-intact skin, contaminated equipment, or the patient environment.
- Perform hand hygiene after removing gloves.
- Use alcohol-based hand rub for routine hand hygiene unless soap and water are required.
- Use soap and water when hands are visibly soiled, after restroom use, before eating, and when caring for patients with known or suspected infectious diarrhea, including *C. difficile*.
- Use PPE based on anticipated exposure and the patient's isolation status.
- Follow posted isolation signage and Epic isolation indicators.
- Remove PPE safely and do not wear contaminated PPE between patients, rooms, or public areas.

Key point: Gloves do not replace hand hygiene. PPE must be used correctly, removed safely, and changed between patient care activities.



Bloodborne Pathogens and Exposure Prevention

Licensed independent practitioners and other personnel with occupational exposure to blood or other potentially infectious materials must complete bloodborne pathogens education at initial assignment and annually.

Bloodborne pathogens of primary concern in healthcare include **hepatitis B, hepatitis C, and HIV**.

Exposure may occur through:

- Needlesticks or sharps injuries
- Splashes to the eyes, nose, or mouth
- Contact with non-intact skin
- Contact with contaminated instruments, equipment, or surfaces

Medical staff expectations:

- Treat all blood and body fluids as potentially infectious.
- Use standard precautions and appropriate PPE when exposure is possible.
- Use safety-engineered sharps when available.
- Do not bend, break, manipulate, or recap needles unless required by a specific procedure and performed using an approved safe method.
- Dispose of sharps immediately in approved sharps containers.

Key point: Preventing exposure requires reliable use of standard precautions, PPE, safe sharps handling, and immediate disposal of sharps.



Bloodborne Pathogens Exposure Response

If a blood or body fluid exposure occurs, take immediate action.

For needlesticks, cuts, or contact with non-intact skin:

- Immediately wash or flush the exposed area,
- Notify the appropriate supervisor or clinical leader
- Report to the Emergency Department as soon as possible, preferably within two hours for evaluation and follow-up.

Medical staff expectations:

- Report the exposure immediately according to UTM process.
- Follow the UTM post-exposure evaluation process.
- Do not wait until the end of the shift, procedure, or day to report the exposure.

Timely reporting supports:

- Source-patient testing
- Baseline testing
- Counseling
- Follow-up testing
- Post-exposure prophylaxis when indicated

Key point: Immediate reporting is part of the exposure response. Delayed reporting may delay evaluation, testing, and treatment.

Safe Injection and Medication Practices

Safe injection practices are part of standard precautions and help prevent transmission of infection between patients, providers, and others.

Medical staff expectations:

- Prepare injections and medications using aseptic technique.
- Perform hand hygiene before medication preparation and administration.
- Clean vial tops with alcohol before access.
- Use a new sterile needle and syringe for each injection and each patient.
- Never reuse a needle or syringe.
- Never re-enter a vial with a used needle or used syringe.
- Use single-dose vials for one patient only.
- Avoid multi-dose vials when possible. If used, date the vial when opened, store according to policy and manufacturer instructions, and discard according to manufacturer instructions or within 28 days unless otherwise specified.
- Do not leave a needle in a vial to be attached to a new syringe.
- Stop and clarify if medication preparation, vial use, sterility, or storage is uncertain.

Key point: Unsafe injection practice is a preventable patient safety risk. Needles and syringes are single-patient use only.



Preventing HAIs: Provider Actions

Provider decisions directly affect the risk of healthcare-associated infections.

Medical staff expectations:

- Use invasive devices only when clinically indicated.
- Review the ongoing need for central lines, urinary catheters, drains, tubes, and other invasive devices.
- Remove invasive devices as soon as they are no longer clinically necessary.
- Use aseptic technique for procedures and line/device insertion.
- Follow UTMHC central line, urinary catheter, surgical/procedural, wound, and device-related infection prevention policies.
- Support timely isolation when infection or MDRO risk is identified.
- Document indications for invasive devices, infection-related diagnoses, and treatment plans clearly.
- Respond to infection prevention concerns raised by nursing, Infection Prevention, Pharmacy, or other team members.



CLABSI, CAUTI, C. difficile, SSI, MDRO Prevention

Medical staff are expected to support prevention of common HAIs through reliable clinical practice.

- **CLABSI:** Use appropriate indications, maximal sterile barrier precautions for insertion, chlorhexidine skin antisepsis unless contraindicated, and daily review of line necessity.
- **CAUTI:** Avoid urinary catheters for convenience or incontinence management when alternatives are appropriate. Document indication and remove as soon as possible.
- **C. difficile:** Use antibiotics appropriately, place patients on enteric/contact-D precautions when indicated, use soap and water after care, and support environmental cleaning practices.
- **SSI:** Follow preoperative, intraoperative, and postoperative infection prevention practices, including appropriate antimicrobial prophylaxis, aseptic technique, and wound care expectations.
- **MDROs:** Promptly recognize prior history or current infection/colonization, follow isolation precautions, and collaborate with Infection Prevention when transmission risk is identified.



Antimicrobial Stewardship

UTMC's antimicrobial stewardship program supports safe, effective antimicrobial use and reduces avoidable adverse events, resistance, and C. difficile risk. CMS specifically includes optimization of antibiotic use through stewardship as part of the hospital infection prevention and control Conditions of Participation.

Medical staff expectations:

- Document the indication for antimicrobial therapy.
- Order the appropriate drug, dose, route, and duration.
- Obtain cultures before antibiotics when clinically appropriate and when doing so will not delay urgent treatment.
- Reassess antimicrobial therapy at 48–72 hours based on culture results, clinical response, and diagnostic information.
- De-escalate, discontinue, or narrow therapy when appropriate.
- Follow UTMC guidelines, order sets, restriction criteria, and stewardship recommendations.
- Consult Infectious Disease or Pharmacy when antimicrobial selection, duration, or resistance concerns are complex.

Key point: Antibiotic stewardship is a medical staff responsibility. Clear indication, appropriate duration, reassessment, and de-escalation reduce patient harm and resistance.

Healthcare Worker Immunizations and Illness Reporting

Healthcare personnel vaccination and illness reporting help protect patients, staff, and high-risk populations.

Medical staff expectations:

- Comply with UTMC Employee Health and Medical Staff requirements for immunization, screening, and documentation.
- Follow the annual influenza vaccination or approved exemption process.
- Complete Hepatitis B vaccination or declination requirements when occupational exposure risk applies.
- Do not report to work or provide patient care when illness may place patients or others at risk.
- Follow Employee Health and Infection Prevention direction for work restrictions, exposures, communicable diseases, and return-to-work requirements.
- Promptly report occupational exposures or communicable disease concerns according to UTMC process.



When Providers Should Contact Infection Prevention

Contact Infection Prevention promptly when you identify:

- A suspected outbreak, unusual cluster, or possible transmission between patients.
- A patient with a suspected high-consequence infection or uncertainty about the required isolation or PPE.
- An MDRO or other infectious risk that may affect placement, procedures, or exposure management.
- A possible reportable disease or a concern involving contaminated equipment, water, construction dust, mold, or a failure in cleaning, disinfection, or sterilization.

Act while you escalate: Initiate indicated precautions, communicate the concern to the care team, and follow UTMHC policy. For a personal blood or body fluid exposure, also follow the Occupational Health exposure process. If Infection Prevention is unavailable and the risk is urgent, escalate through the unit leader or hospital leadership.



Patient Rights, Communication, Equity, and Consent



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Patient Rights and Participation in Care

UTMC medical staff are expected to support patient rights and provide care that respects the patient's dignity, privacy, values, culture, communication needs, and right to participate in care decisions.

Medical staff expectations:

- Respect the patient's right to receive information about their diagnosis, treatment options, risks, benefits, alternatives, and expected outcomes in a way they can understand.
- Support the patient's right to ask questions, participate in care decisions, accept treatment, refuse treatment, or request a second opinion when appropriate.
- Use interpreter services, communication aids, or other support when needed to ensure meaningful communication.
- Respect the patient's privacy, confidentiality, cultural beliefs, spiritual needs, personal values, and personal dignity.
- **Key point:** Patient rights are part of everyday clinical care and communication.



Complaints, Grievances, and Non-Retaliation

Patients, families, guardians, or legally authorized representatives have the right to voice complaints or grievances about care, treatment, services, safety, or patient rights.

Medical staff expectations:

- Address concerns respectfully when they arise.
- Escalate unresolved concerns through the appropriate UTMC process, including department leadership, patient advocate/service excellence, nursing leadership, quality/risk, or hospital leadership as appropriate.
- Do not retaliate or respond negatively when a patient or representative raises a concern, complaint, or grievance.
- Support timely review and follow-up when medical staff input is needed for a complaint or grievance response.
- **Key point:** A complaint or grievance should never affect the patient's access to care, treatment decisions, or how the patient is treated.



Advance Directives and Visitation/Support Person Rights

Patients have the right to formulate advance directives and to have those directives considered in care decisions, consistent with law and UTMCM policy.

Medical staff expectations:

- Review and honor valid advance directives, code status decisions, and legally authorized decision-maker roles according to UTMCM policy.
- Clarify goals of care, treatment preferences, and decision-maker authority when needed.
- Involve Ethics, Risk Management, Legal Affairs, or appropriate leadership when advance directives, code status, surrogate decision-making, or treatment refusal creates uncertainty.

Patients also have the right to designate visitors and support persons, including a spouse, domestic partner, family member, friend, or other individual of their choice, consistent with patient preference and UTMCM policy.

Visitation or support person restrictions should be based on clinical, safety, infection prevention, privacy, operational, or legal considerations and should not be applied in a discriminatory manner.

Key point: Medical staff should honor the patient's choices and involve appropriate resources when the patient's wishes, legal authority, or clinical situation is unclear.



Health Equity and Respectful Care

UTMC medical staff are expected to provide care that is respectful, equitable, and responsive to each patient's needs, values, culture, beliefs, communication preferences, and health circumstances.

Medical staff expectations:

- Provide medically appropriate care without discrimination based on race, color, national origin, ethnicity, language, religion, sex, sexual orientation, gender identity or expression, age, disability, socioeconomic status, payer source, or other protected status.
- Recognize that social drivers of health, such as transportation, food insecurity, housing instability, financial strain, health literacy, disability, and caregiver support, may affect diagnosis, treatment, follow-up, and outcomes.
- Consider whether barriers to care may affect the patient's ability to understand instructions, access medications, attend follow-up appointments, obtain testing, or safely manage care after discharge.
- Use respectful language and ask patients how they would like to be addressed.
- Involve appropriate UTMC resources when social, cultural, financial, language, disability, or access needs may affect care or discharge planning.

Key point: Health equity is part of safe clinical care. Medical staff support equity by recognizing barriers, communicating clearly, and connecting patients to appropriate resources.

Communicate So Patients Can Participate in Care

Provider responsibilities:

- Identify language, hearing, vision, speech, or other communication needs before a consequential care discussion.
- Ask the patient what communication method works for them. Arrange an appropriate interpreter, auxiliary aid, or accessible material when needed.
- Explain the diagnosis, options, risks, medications, and follow-up in plain language. Allow time for questions and confirm understanding, especially during consent and discharge discussions.
- Document communication needs and the support used. If communication remains unclear, pause the discussion and obtain effective support.



Interpreter Services: Provider Responsibilities

- Offer a qualified interpreter at no cost when interpretation is needed for the patient or an appropriate representative. Use UTMHC's remote video interpreter system; call Nursing Administration at ext. 5003 for assistance.
- Use qualified interpretation for histories, assessments, informed consent, treatment decisions, medication teaching, and discharge planning. Arrange qualified sign language interpretation when needed.
- Do not require the patient to provide an interpreter. Never use a minor child. An adult family member may interpret medical information only when the patient declines qualified services and the applicable federal safeguards are met: the patient makes the request privately with a qualified interpreter present, the adult agrees, and using the adult is appropriate.
- In an imminent emergency, provide necessary care while obtaining a qualified interpreter. Have the interpreter confirm or supplement any initial communication.
- Document the need, primary language, interpreter identity, date and time, discussion topic, and verification of understanding. If qualified services are declined, document the refusal and the permitted alternative used.



Informed Consent – Medical Staff Responsibilities

Informed consent is a patient right and medical staff responsibility.

The physician, dentist, or other healthcare provider privileged to perform the treatment, or procedure is responsible for providing the information needed for informed consent and answering the patient's or legally authorized representative's questions.

The discussion should include:

- The nature and purpose of the proposed treatment or procedure.
- Expected outcome and likelihood of achieving it.
- Reasonably known risks and benefits.
- Alternatives and their material risks and benefits.
- Probable consequences of declining treatment.
- Effects and risks of receiving no treatment.
- Associated treatment modalities, including anesthesia and blood transfusion when applicable.
- Participation of other practitioners or trainees in important procedural tasks when applicable.

Key point: Consent is more than a signed form. It requires a meaningful discussion and clear documentation in the medical record.



Informed Consent – Communication and Documentation

The practitioner performing the treatment or procedure is responsible for explaining its purpose, expected benefits, material risks, and reasonable alternatives, and for answering the patient's or legally authorized representative's questions. Use a qualified interpreter when needed.

When UTMC policy requires written consent, ensure the consent form is completed, signed, witnessed, dated, and timed before treatment or procedure begins. The practitioner who provided the explanation should document the discussion in the medical record if they did not sign the consent form.

Confirm that required consent documentation is complete before premedication, analgesia, or moderate sedation is given, unless an applicable emergency exception permits care to proceed.

Key point: The signed form records the patient's decision. The medical record should also show that the practitioner explained the care and answered questions.



Informed Consent Off-Label, Investigational, or Experimental Therapy

UTMC requires informed consent for off-label drug therapy. Research, investigational products, clinical trials, and expanded-access treatment must also follow applicable IRB, FDA, pharmacy, and institutional requirements. When applicable, the practitioner must clearly explain:

- The clinical rationale for the treatment.
- Known and potential risks.
- Expected benefits.
- Reasonable alternatives.
- The uncertainty related to the treatment.
- Any additional review, consent, pharmacy, IRB, FDA, or UTMC policy requirements.
- Research, investigational drug, expanded access, or compassionate-use situations must follow applicable regulatory and UTMC policy requirements.

Key point: When treatment is outside usual standard practice, the consent discussion must clearly address the rationale, uncertainty, risks, alternatives, and required approval pathway.



Informed Consent

Blood and Blood Product Consent

For blood or blood product administration, the patient or legally authorized representative must receive information about:

- The reason for transfusion.
- Expected benefit.
- Material risks.
- Alternatives when applicable.
- Risks of refusing transfusion.

Consent must be obtained and documented according to UTMC policy before non-emergent blood or blood product administration.

Key point: Blood and Blood Product transfusion consent require clear discussion of the reason for treatment, material risks, alternatives, and refusal risks.



Abuse, Neglect, Exploitation, and Mandatory Reporting



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Abuse, Neglect, Exploitation, and Mandatory Reporting

UTMC medical staff are expected to recognize, respond to, document, and report suspected abuse, neglect, exploitation, self-neglect, or unsafe care situations according to Ohio law and UTMC policy.

Reporting is based on **reasonable suspicion or reasonable cause**. Medical staff do not need proof, and medical staff are not responsible for investigating whether abuse occurred.

Medical staff expectations:

- Recognize history, physical findings, behavior, caregiver interaction, or safety concerns that may indicate abuse, neglect, exploitation, or self-neglect.
- Take immediate action to protect the patient's safety, privacy, and dignity.
- Report suspected abuse, neglect, exploitation, or unsafe circumstances to the appropriate agency or authority according to patient age, condition, residence, and setting.
- Document objective findings, patient or caregiver statements, observed behaviors, injuries, actions taken, and the agency or person receiving the report.
- Escalate concerns through UTMC leadership, Social Work/Care Management, Security, Risk Management, Legal Affairs, or the appropriate clinical leader when needed.
- Internal notification to Social Work, Risk Management, Security, or leadership does not replace a legally required report to an outside authority.
- Do not wait for confirmation before reporting when there is reasonable suspicion.

Key point: Medical staff are responsible for recognizing concerns, protecting the patient, reporting promptly, and documenting objectively. Investigation is handled by the appropriate authority.



Child Abuse and Neglect: Medical Staff Responsibilities

UTMC medical staff must immediately report suspected child abuse, neglect, exploitation, battery, or sexual exploitation according to Ohio law and UTMC policy.

Reporting is based on **reasonable suspicion**. Medical staff do not need proof and should not delay reporting while trying to confirm whether abuse occurred.

Possible indicators may include:

- History that is inconsistent with the injury, developmental level, or physical findings.
- Vague, changing, or contradictory explanations.
- Significant injury identified when the child presents with a minor complaint.
- Unusual bruising patterns, injuries in different stages of healing, or injuries suggestive of an instrument.
- Unexplained central nervous system findings in an infant or young child.
- Concern for sexual abuse, genital or rectal trauma, sexually transmitted infection, pregnancy in a child, or sexualized behavior inconsistent with age.
- Concern that a sibling or another child may be at risk.

Medical staff should take immediate action to protect the child, report to the appropriate children's services and law enforcement authorities, and escalate internally through the UTMC process when needed.

Key point: Do not investigate or conduct a formal forensic interview. Protect the child, report promptly, and document objective findings and spontaneous statements.



Adult Abuse, Neglect, Exploitation and Self-Neglect

Providers must respond when they have reasonable cause to suspect abuse, neglect, exploitation, self-neglect, or an injury caused by violence. Proof is not required before making a report.

Assess and address the patient's immediate safety and medical needs. Document the patient's statements, examination findings, and the basis for the concern using objective language.

The required reporting agency depends on the circumstances:

- For an older adult who meets Ohio's adult protective services criteria, report immediately to the appropriate county adult protective services agency.
- For a patient with a developmental disability, a nursing home resident, or a patient with an injury related to an offense of violence, follow the specific reporting pathway in UTMCM policy.
- For other adults experiencing violence or abuse, follow UTMCM's domestic violence policy and applicable reporting requirements.

Document whom you contacted and when. Involve Social Work, Security, or Risk Management as needed, but do not substitute internal notification for a required external report.

Key point: Protect the patient, report through the pathway that applies to the patient's situation, and document objectively.



Abuse/Neglect Documentation Expectations

When abuse, neglect, exploitation, self-neglect, or unsafe circumstances are suspected, documentation should be objective, factual, and timely.

Medical staff documentation should include:

- Physical and mental status observations
- Description of injuries, including size, type, number, location, and stage of healing
- Patient, child, caregiver, or witness statements in quotation marks when possible
- Observed behavior and interaction with family, caregiver, or accompanying person
- Actions taken to protect the patient
- The agency or individual receiving the report
- Security, law enforcement, Social Work, Risk Management, or leadership involvement when applicable

Key point: Document what was seen, heard, reported, and done. Avoid conclusions or personal opinions.



Photographs, Escalation, and Safety Concerns

Photographs may be taken when injuries or suspicious findings are present, according to UTMC policy.

Medical staff should ensure the medical record reflects when photographs are taken and follow the required process for patient identification and image handling.

Escalate immediately when there is:

- Immediate danger to the patient, staff, or others
- Concern for trafficking, sexual assault, or unsafe discharge
- Threats from caregivers, visitors, or others
- Weapons or security concerns
- Concern that another child, dependent adult, or vulnerable person may be at risk
- Need for urgent Social Work, Security, Risk Management, Legal Affairs, or leadership involvement

Key point: Protect the patient, report promptly, document objectively, and escalate safety concerns through the appropriate UTMC pathway.



Behavioral Health Safety and Restraint/Seclusion



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Suicide/Self-Harm Risk: Provider Responsibilities

Medical staff are expected to recognize and escalate suicide, self-harm, behavioral health, and safety risks.

Medical staff expectations:

- Respond immediately to suicidal statements, intent, plans, or behavior. Assess the patient and coordinate the C-SSRS screening process with Nursing.
- Initiate precautions based on the identified risk. Nursing may begin precautions before a provider order and notify the physician.
- For high-risk patients, ensure **direct, continuous 1:1 observation**, including during toileting and transport. Address environmental hazards with the care team.
- Obtain Psychiatry consultation for moderate- or high-risk patients.
- Document your assessment, risk level and rationale, precautions, consultation, and treatment plan.
- The physician or designee must reevaluate the need for precautions **every 24 hours**, and sooner when the condition changes.
- Communicate current risk and precautions during handoff. Address safety planning and follow-up before discharge.

Key point: Put immediate safety measures in place while assessment and consultation proceed.



Clinical Decision Scenario: Suicidal Intent During Medical Care

Situation:

A patient admitted for pneumonia tells you, “I have a plan to kill myself when I get home.”

Decision point:

What must be in place before you leave the bedside?

Expected provider response:

- Assess suicidal intent, the plan, access to means, and immediate safety.
- Notify Nursing and initiate suicide precautions. Ensure continuous 1:1 observation while urgently assessing the disclosed intent and plan.
- Obtain Psychiatry consultation and continue necessary medical treatment.
- Document the assessment, precautions, and plan.
- Give a direct handoff confirming who will maintain observation.

Key point: A Psychiatry consult request does not replace immediate protection of the patient.



Restraint and Seclusion: Core Medical Staff Responsibilities

Patients have the right to be free from restraint or seclusion unless it is needed to protect the immediate physical safety of the patient, staff, or others.

All medical staff should understand patients' restraint-related rights. Practitioners authorized to order restraints must know and follow the ordering, evaluation, renewal, documentation, and notification requirements in UPMC policy.

Restraint or seclusion must never be used for coercion, discipline, convenience, or retaliation.

Medical staff are expected to:

- Use the least restrictive intervention that is safe and effective.
- Order restraint or seclusion only when clinically justified and consistent with UPMC policy.
- Ensure the order matches the patient's behavior, condition, and reason for restraint.
- Respond promptly to requests for orders, renewal, reassessment, or discontinuation.
- Discontinue restraint or seclusion at the earliest safe time.
- Standing or PRN restraint/seclusion orders are not permitted.

Key point: Restraint and seclusion may only be used when clinically necessary, safely applied, time-limited, monitored, and discontinued as soon as possible.



Medication and Chemical Restraint

A medication is a chemical restraint when it is used to restrict a patient's movement or manage behavior and is not standard treatment or a standard dosage for the patient's condition.

In UTMC inpatient psychiatry, chemical restraint is prohibited.

When ordering medication for agitation or behavioral symptoms, providers should:

- Assess the patient and identify a clinical indication for treatment.
- Select a medication and dose appropriate for the patient's condition.
- Document the symptoms, treatment rationale, patient response, and reassessment.
- Never order medication for staff convenience, punishment, or coercion.

Key point: A medication used as appropriate treatment for an assessed condition is distinct from a medication used to restrict the patient's movement. Document the clinical reason and response.



Nonviolent vs Violent/Self-Destructive Restraint

The restraint category is based on **why restraint is being used**, not only the device.

Nonviolent / non-self-destructive restraint is used when the patient is not violent or self-destructive, but restraint is needed to protect medical treatment or prevent unintentional harm.

Examples may include:

- A confused patient pulling at an endotracheal tube.
- A patient repeatedly removing a central line, feeding tube, drain, Foley catheter, oxygen device, or surgical dressing.
- A patient unable to follow safety instructions and at risk of disrupting necessary care.

Violent / self-destructive restraint or seclusion is used only when the patient's behavior creates an immediate physical safety risk to self, staff, or others.

Examples may include:

- A patient physically attacking staff.
- A patient actively attempting self-harm.
- A patient throwing objects or attempting to injure others.
- A patient whose behavior cannot be safely managed with less restrictive interventions.

Key point: The same device, such as soft wrist restraints, may be nonviolent or violent/self-destructive depending on the patient's behavior and the reason for use.

Nonviolent Restraint: Ordering and Renewal

Nonviolent restraint may be ordered when a patient is interfering with necessary medical treatment and less restrictive measures have been ineffective.

Before ordering, assess the patient's condition and document the behavior, clinical reason for restraint, alternatives attempted, restraint type, and criteria for release.

- A physician, CNP, PA, or CNS authorized by UTM policy may order restraint. PRN orders are not permitted.
- The physician must be contacted promptly and must see the patient by the next calendar day.
- Orders expire at the end of the calendar day. If restraint remains necessary, a physician must reevaluate the patient and renew the order each calendar day.
- If restraint is discontinued and later needed again, write a new order.

Key point: Reassess the clinical need for restraint and discontinue it as soon as it is safe to do so.



Clinical Decision Scenario: Nonviolent Restraint – Provider Decision

Situation:

You are the treating LIP or APP on an acute care unit. A patient with delirium repeatedly pulls at a necessary central line. Reorientation, closer observation, and other less restrictive measures have not kept the line safe. The care team asks whether soft wrist restraints may be used.

Decision point:

What must you assess, order, and document before restraint is used?

Expected provider response:

- Assess the patient's condition, the risk to necessary treatment, and the alternatives attempted.
- If authorized to order restraint, write a nonviolent restraint order specifying the behavior, clinical reason, restraint type, and criteria for release. Do not use a PRN order.
- Ensure the physician is notified as required. Under UTMHC's acute care policy, the physician must see the patient by the next calendar day and reevaluate and reorder restraint each calendar day if it remains necessary.
- Document the assessment and discontinue restraint as soon as it can safely be removed. If it is discontinued and later needed again, obtain a new order.

Key point: The order must reflect the patient's current need to protect necessary treatment.



Violent/Self-Destructive Restraint or Seclusion: Ordering and One-Hour Evaluation

Order restraint for violent or self-destructive behavior only when the patient presents an immediate physical safety risk and less restrictive measures have failed or cannot be used safely.

PRN and standing orders are not permitted.

An authorized provider must complete or arrange the required face-to-face evaluation within one hour of initiation.

- Document the patient's immediate situation, reaction to the intervention, medical and behavioral condition, and whether restraint should continue.

Setting-specific requirement: UTMHC acute care does not use seclusion. In inpatient psychiatry, a physician must evaluate the patient within one hour after restraint or seclusion begins and follow the psychiatry policy for ongoing evaluation.

Key point: The order and evaluation must reflect the patient's current behavior and need for continued restraint.



Violent/Self-Destructive Restraint or Seclusion: Time Limits

The maximum duration of each order depends on the patient's age:

- Age 18 or older: 4 hours
- Ages 9–17: 2 hours
- Under age 9: 1 hour

Medical staff expectations:

- Reassess the patient before renewing an order.
- Renewals may continue within these limits for up to 24 consecutive hours.
- In acute care, a physician must see and evaluate the patient before a new order is initiated at 24 hours.
- In inpatient psychiatry, a physician must perform a face-to-face reevaluation every four hours.
- If restraint or seclusion ends and the behavior recurs, a new order must be written. Do not reuse the previous order, even if time remains.

Key point: Renew restraint only while the patient's current condition supports its use.



Violent/Self-Destructive Restraint or Seclusion: Provider Documentation

- **Document the immediate safety risk:** Describe the patient's behavior, the less restrictive measures attempted, and why restraint or seclusion was necessary.
- **Complete the order:** Record the restraint type, date and time, applicable time limit, and criteria for discontinuation.
- **Document the one-hour evaluation:** Record the patient's immediate situation, response to the intervention, medical and behavioral condition, and whether continued use is necessary.
- **Reassess before renewal:** Document the current behavior supporting continued use. Discontinue the intervention as soon as it is no longer needed, even if the order has time remaining.
- **Escalate serious injury or death immediately** through the UTMC reporting process. This includes a death during restraint or seclusion, within 24 hours after removal, or within one week when restraint or seclusion may have contributed. Quality/Risk will determine the applicable CMS reporting or internal log process.

Setting reminder: Seclusion is used only in UTMC inpatient psychiatry; follow that unit's additional physician evaluation requirements.



EMTALA and Emergency Screening Responsibilities



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EMTALA: Medical Staff Responsibilities

UTMC provides an appropriate Medical Screening Examination to individuals who present to the Emergency Department or applicable UTMC property requesting or requiring examination or treatment for a possible emergency medical condition.

Medical staff expectations:

- Provide or support an appropriate Medical Screening Examination within UTMC's capability.
- Do not delay the Medical Screening Examination to ask about insurance, payment, authorization, or financial status.
- Stabilize an identified Emergency Medical Condition within UTMC's capability.
- Arrange an appropriate transfer when the patient requires services not available at UTMC or when transfer is otherwise clinically indicated.

Follow UTMC's Emergency Medical Screening and Transfer Policy. (3364-100-53-24)

Medical Screening Examination

A Medical Screening Examination (MSE) is the process used to determine, with reasonable clinical confidence, whether an Emergency Medical Condition exists.

The MSE may include history, physical examination, vital signs, mental status assessment, diagnostic testing, imaging, EKG, laboratory testing, or other focused assessment based on the patient's presenting complaint.

Triage is not the same as a Medical Screening Examination.

- Triage determines the order in which patients are seen;
- The MSE determines whether an Emergency Medical Condition exists.

The medical record must reflect the MSE findings, testing and analysis when applicable, determination of whether an Emergency Medical Condition exists, patient disposition, education, and follow-up plan when discharged.



Stabilization and Transfer

If an Emergency Medical Condition exists, UTMHC must provide stabilizing treatment within its capability or arrange an appropriate transfer.

An unstable patient may be transferred only when:

- The patient or legally responsible representative requests transfer after being informed of UTMHC's obligation to examine and stabilize and the risks of transfer; or
- A physician certifies that the medical benefits of transfer outweigh the risks.

An appropriate transfer requires:

- Acceptance by the receiving facility,
- Appropriate mode of transportation,
- Qualified personnel/equipment as needed, and
- Transfer of relevant medical records available at the time of transfer.



On-Call Medical Staff Responsibilities

UTMC maintains an on-call schedule that identifies the physician responsible for each covered service.

Unless a contract or agreement requires a shorter response time, on-call physicians must:

- Be available by phone within 5 minutes.
- Arrive at the hospital within the applicable timeframe:
 - **Cardiothoracic services:** Within 30 minutes of notification that services are needed. For lifesaving procedures, this requirement may be met by a cardiothoracic surgeon or a trauma/general surgeon with experience in cardiothoracic surgery.
 - **All other services:** Within 60 minutes of notification that services are needed.
- **Trauma attending requirement:** If a resident fulfills the trauma surgeon requirement, the attending trauma surgeon must be present at the hospital within 30 minutes of the decision to operate.
- The physician must respond sooner when the patient's condition requires it. If the needed specialty is unavailable, the Emergency Department must continue care within UTMC's capability and arrange an appropriate transfer when indicated.

Key point: Be reachable, respond within the applicable timeframe, and communicate promptly with the Emergency Department about the patient's needs and plan of care.



Pregnant Patients and Labor

A pregnant patient who presents in labor to the Emergency Department or applicable UTMC property must receive a Medical Screening Examination and necessary stabilizing treatment.

The medical record must document the labor assessment, including:

- Regularity and duration of contractions.
- Fetal position and station.
- Cervical dilation.
- Status of membranes.

A patient experiencing contractions is considered to be in true labor unless a physician certifies, after a reasonable period of observation, that the patient is in false labor. The physician must document the false-labor certification and whether the determination followed a physical examination or consultation with the Qualified Medical Person performing the examination.

A pregnant patient in active labor is considered unstable for EMTALA purposes and may only be transferred according to EMTALA transfer requirements.



Obstetrical Emergency Readiness Screening and Stabilization

UTMC does not provide routine obstetrical or neonatal services, but providers must respond when a pregnant, birthing, postpartum, or newborn patient presents with an emergency.

- Begin the medical screening examination and stabilizing treatment within UTMC's capability.
- Activate UTMC-approved response pathway following the obstetrical emergency response protocol.
- Emergency equipment, medications, blood products, and newborn supplies are located in the Emergency Department.
- Continue necessary care while arranging an appropriate transfer when needed. Communicate the condition, treatment, and immediate needs to the receiving team.
- Document the assessment, response, consultations, condition before transfer, and transfer arrangements.

Key point: Know where to find the protocol and resources before an emergency occurs.



Obstetrical Emergency Readiness Transfer and Documentation

When a patient or newborn needs services beyond UTMC's capability, continue stabilizing care and arrange an appropriate transfer under EMTALA and UTMC policy.

Document the care provided, including:

- Screening findings and the patient's condition.
- Maternal and fetal or newborn assessments, as applicable.
- Treatment, response, and consultations.
- The reason for transfer and the patient's condition before transfer.
- The risks and benefits discussed, required transfer certification or patient request, receiving facility acceptance, and transport arrangements.

Communicate the patient's condition, treatment, and immediate needs to the receiving team. If delivery occurs at UTMC, follow the applicable maternal and newborn emergency protocols.

Key point: The record should show the emergency response, care provided within UTMC's capability, and how the transfer was arranged.



Patients Who Leave Before Completion of Care

If a patient decides to leave before the Medical Screening Examination or before recommended treatment/transfer is completed, staff should make reasonable efforts to:

- Explain the importance of the Medical Screening Examination or recommended care.
- Use interpreter services or alternate communication methods when needed.
- Inform the patient of the risks of leaving.
- Request that the patient sign the appropriate AMA/refusal documentation.

Document the discussion, risks explained, refusal to sign if applicable, and the patient's departure.

EMTALA – Documentation Expectations

Medical staff documentation must clearly support EMTALA compliance.

Documentation should include, when applicable:

- Medical Screening Examination findings.
- Whether an Emergency Medical Condition was identified.
- Stabilizing treatment provided within UTMC's capability.
- Patient condition before discharge or transfer.
- Consultations obtained and recommendations received.
- Transfer risks and benefits discussed with the patient or legally authorized representative.
- Physician certification when an unstable transfer is medically necessary.
- Patient request for transfer or refusal of examination, treatment, or transfer when applicable.
- Receiving facility acceptance, accepting provider, mode of transport, and transfer plan.
- Patient education, discharge instructions, follow-up plan, and disposition.

Key point: The medical record should show what was assessed, what was determined, what was done, and why the patient was discharged, transferred, admitted, or left before care was complete.

EMTALA – Escalation, Reporting, and Non-Retaliation

EMTALA concerns should be escalated promptly.

Report concerns through the appropriate UTMC process, which may include:

- Emergency Department leadership.
- Medical staff leadership or department chair.
- Risk Management.
- Legal Affairs.
- Compliance Hotline or compliance reporting process.
- Quality and Patient Safety, when applicable.

Examples of concerns that should be escalated include:

- Delay or refusal of a Medical Screening Examination.
- Delay in stabilizing treatment.
- Transfer concerns involving an unstable patient.
- Failure to obtain receiving facility acceptance before transfer.
- Incomplete transfer documentation.
- Questions about on-call response obligations.
- Patient leaving before completion of the MSE, treatment, or transfer process.

UTMC will not penalize or take adverse action against a physician, Qualified Medical Person, or employee who reports an EMTALA concern or refuses to authorize transfer of an unstabilized patient when transfer is not appropriate.

Key point: When EMTALA compliance is uncertain, escalate early. Patient safety, appropriate screening, stabilization, transfer, and accurate documentation are the priorities.

Medication, Treatment, and Diagnostic Safety



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Medication Management and High-Alert Medications

Safe medication management is a shared responsibility. Medical staff support medication safety through clear prescribing, appropriate monitoring, and timely communication with Pharmacy, Nursing, and the care team.

Medical staff expectations:

- Order medications using UPMC-approved order sets, protocols, and formulary processes when applicable.
- Use additional caution with high-alert medications, including anticoagulants, insulin, opioids, sedatives, concentrated electrolytes, chemotherapy/antineoplastic agents, neuromuscular blockers, and other medications identified by UPMC policy.
- Document the indication, dose, route, frequency, duration, monitoring parameters, and clinical rationale when needed for safe use.
- Review allergies, renal/hepatic function, age, weight, pregnancy/lactation status when applicable, drug interactions, duplicate therapy, and relevant lab values before and during therapy.
- Label medications, syringes, basins, and solutions in procedural or sterile fields when not immediately administered.

Key point: High-alert medications are not always more likely to be ordered incorrectly, but when errors occur, the risk of serious patient harm is higher.



Adverse Drug Events and Medication Safety Reporting

Medical staff are expected to respond promptly to medication-related safety concerns and report adverse drug events, medication errors, near misses, and unsafe medication conditions.

Medical staff expectations:

- Respond promptly to critical values, abnormal monitoring results, pharmacy questions, nursing concerns, adverse effects, oversedation, or suspected medication-related harm.
- Reconcile medications during admission, transfer, discharge, and transitions of care to reduce omissions, duplications, interactions, and dosing errors.
- Communicate medication changes, high-risk medication plans, monitoring needs, and follow-up requirements during handoff and discharge.
- Report adverse drug events, medication errors, near misses, unsafe conditions, and high-alert medication concerns through the UTMC event reporting process.
- Escalate serious or unexpected medication-related harm through the appropriate clinical, pharmacy, quality/risk, or leadership pathway.

Key point: Reporting medication events and near misses supports patient safety, process improvement, and prevention of future harm.



Critical Results and Diagnostic Follow-Up

Medical staff are responsible for timely review, communication, and action on critical results and significant diagnostic findings.

Medical staff expectations:

- Respond promptly to critical values, critical tests, abnormal results, and clinically significant findings.
- Document the clinical response, follow-up plan, new orders, notification, or rationale when no additional action is required.
- Communicate significant findings to the appropriate care team member, consultant, patient, or responsible provider when needed.
- Ensure handoff includes pending tests, critical follow-up needs, and unresolved diagnostic concerns.
- Do not assume that acknowledgement of a result means appropriate clinical action has occurred.
- Escalate concerns when a critical result, diagnostic finding, or follow-up responsibility is unclear.

Key point: Closed-loop communication means the result is received, understood, acted upon, documented, and communicated to the responsible party.



Clinical Decision Scenario: Critical Results after Discharge

You are the LIP or APP covering the ordering provider. A radiology report is finalized after discharge and identifies a finding that needs prompt follow-up. The ordering provider is away.

What is your responsibility?

- Review the result in the context of the patient's record and determine its clinical significance.
- Arrange the needed patient contact, treatment, or follow-up within your scope. Involve the responsible physician or service when needed.
- Give any remaining task to an identified provider rather than leaving it in an unattended inbox.
- Document your assessment, communication attempts, plan, and who will complete follow-up.

Decision point: Who is responsible for acting on the result today?

The covering provider reviews the finding, arranges timely patient contact and follow-up, documents the plan, and identifies who will complete any remaining action.



Pain Management and Opioid Safety

Medical staff are expected to support safe, individualized pain management while reducing avoidable harm from opioids and other high-risk medications.

Medical staff expectations:

- Assess pain and functional goals based on the patient's condition, procedure, diagnosis, and care plan.
- Use multimodal and non-opioid options when clinically appropriate.
- Consider patient-specific risk factors, including age, renal/hepatic function, sleep apnea, respiratory status, substance use history, sedation risk, concurrent sedatives, and opioid tolerance.
- Order opioids and sedating medications cautiously and monitor for oversedation, respiratory depression, hypotension, delirium, falls, and other adverse effects.
- Reassess pain, medication response, side effects, and need for ongoing therapy.
- Educate patients and caregivers on safe medication use, side effects, storage, disposal, and when to seek help.
- Document the pain management plan, patient response, and follow-up needs.

Key point: Safe pain management balances relief, function, patient-specific risk, reassessment, and prevention of medication-related harm.

Clinical Alarms: Provider Responsibilities

- Order monitoring that matches the patient's condition, risk, and level of care. Reassess the need for monitoring when the patient's condition or care setting changes.
- Work with nursing and respiratory therapy to set patient-specific alarms that identify clinically significant changes.
- **When alarm limits need to be set outside UTMHC's established parameters, review the clinical reason and provide the required order.** Do not direct staff to disable or silence an alarm needed for patient safety.
- Respond to concerns about repeated alarms, inappropriate limits, or a change in the patient's condition. Revise the monitoring plan when indicated.
- Communicate essential monitoring needs during handoff and transfer. Discontinue monitoring when it is no longer clinically indicated.

Key point: The provider determines the clinical monitoring need and orders exceptions to established alarm parameters; the care team sets, checks, and responds to alarms under UTMHC policy.



Anticoagulation Therapy Safety Ordering and Monitoring

Anticoagulants are high-alert medications that require careful ordering, monitoring, and follow-up.

Medical staff are expected to:

- Order anticoagulants using UTMCM-approved protocols, order sets, and evidence-based guidelines.
- Document the indication for anticoagulation and intended duration when known.
- Review patient-specific risk factors before and during therapy, including renal function, weight, age, bleeding risk, allergies, platelet count, drug interactions, and relevant laboratory values.
- Avoid duplicate anticoagulant or antiplatelet therapy unless clinically indicated and clearly documented.
- Use approved protocols for heparin, warfarin, direct oral anticoagulants, low molecular weight heparin, peri-procedural management, reversal, and bridging when applicable.
- Respond promptly to critical values, bleeding concerns, supratherapeutic anticoagulation, or requests for reversal guidance.

Key point: Safe anticoagulation requires a clear indication, correct dose, appropriate monitoring, and timely response to abnormal findings.



Anticoagulation Therapy Safety Communication and Patient Education

Anticoagulation safety depends on reliable communication across care transitions.

Medical staff are expected to communicate anticoagulation plans during:

- Handoff
- Transfer
- Discharge
- Peri-procedural planning
- Changes in level of care
- Transitions to outpatient follow-up

When anticoagulation will continue after discharge, patients and caregivers should receive education on:

- Medication purpose and dose
- How and when to take the medication
- Bleeding precautions
- Monitoring and follow-up needs
- Diet or drug interaction concerns when applicable
- When to seek urgent medical attention

Key point: Anticoagulation harm often occurs during transitions of care. Clear instructions, follow-up plans, and patient education reduce risk.

Blood Transfusion Safety Ordering, Consent, and Monitoring

Blood and blood products are high-risk therapies that require appropriate indication, patient identification, consent, monitoring, and clear communication.

Medical staff are expected to:

- Order blood and blood products only when clinically indicated and consistent with UTMC policy.
- Ensure the patient or legally authorized representative receives information about the reason for transfusion, expected benefit, material risks, alternatives when applicable, and the risk of refusing transfusion.
- Confirm that transfusion consent is obtained and documented before non-emergent transfusion according to UTMC policy.
- Use clear orders that identify the blood product, amount, rate or administration instructions when applicable, special product requirements, and clinical indication.
- Respond promptly to nursing, blood bank, or care team concerns related to transfusion safety.

Key point: Safe transfusion practice requires a clear clinical indication, documented consent, accurate orders, correct patient identification, and appropriate monitoring.



Blood Transfusion Safety

Suspected Transfusion Reaction

Medical Staff Response

A transfusion reaction should be considered when a patient develops a new or worsening condition during or after a transfusion.

Possible concerns include fever, chills, rash, shortness of breath, chest or back pain, hypotension, nausea, bleeding, or an acute change in condition.

If a reaction is suspected:

- Stop the transfusion immediately.
- Keep IV access open with normal saline using new tubing.
- Assess and stabilize the patient.
- Notify the blood bank and treating provider.
- Follow the UPMC transfusion reaction protocol.
- Order treatment or testing as clinically indicated.
- Document the assessment, interventions, patient response, and follow-up plan.
- Do not restart the transfusion unless cleared by UPMC policy and blood bank direction.

Key point: Stop the transfusion, stabilize the patient, notify the blood bank, follow the protocol, and document the response.

Specialized Testing and Tissue Safety

Point-of-care testing: Perform only tests for which you have completed required training and competency validation. Follow the approved procedure, quality-control requirements, and process for documenting and acting on results.

Transplantable tissue: If your role includes tissue use, follow UTMC's assigned handling, verification, traceability, documentation, and adverse-event process.

Key point: This overview does not replace the separate education and competency assigned for these activities.

Procedural and Device-Related Safety

*Moderate sedation requirements are addressed in separate education assigned to practitioners whose privileges or responsibilities include sedation.

Central Lines: Provider Decisions and Insertion Safety

Central lines are high-risk invasive devices. Medical staff who insert, order, or manage central lines are expected to follow UTMHC policy and evidence-based practices to reduce central line-associated bloodstream infections.

- **Choose central access only when clinically indicated.** Document the indication and select the line type, number of lumens, and insertion site based on the patient's needs and risks.
- **If you insert the line, follow UTMHC's insertion process:** use ultrasound guidance, hand hygiene, maximal sterile barriers, and the required skin antisepsis. Complete the insertion checklist with the assisting team member; stop and correct any break in sterile technique.
- Document the procedure, site, line type, complications, and confirmation of placement when applicable.
- Review the indication daily with the care team. Remove the line promptly when central access is no longer needed, and address concerns about infection or line function.



Urinary Catheters: Provider Decisions and Removal

Urinary catheters are invasive devices and should only be used when clinically indicated. CAUTI prevention depends on appropriate catheter use, aseptic insertion, maintenance of a closed drainage system, daily review of necessity, and prompt removal when the catheter is no longer needed.

- **Order an indwelling Foley only for a documented clinical indication.** Do not use one solely for convenience, incontinence, confusion, or fall prevention.
- Consider an appropriate alternative when continuous drainage is unnecessary, such as bladder scanning, intermittent catheterization, or an external collection device.
- Review the indication during daily care and at transfers. Support removal under UTMC's **nurse-driven protocol** when criteria are no longer met.
- Respond when nursing identifies a reason to consult the provider before removal, such as difficult placement, urologic injury, recent relevant surgery, or urinary retention.
- Assess symptoms before ordering urine tests or antibiotics; a positive urine result alone does not establish a symptomatic infection.



Universal Protocol and Procedural Verification

Universal Protocol is used to prevent wrong patient, wrong site, wrong side, wrong level, wrong procedure, and wrong implant/device events.

Medical staff expectations:

- Follow UTMHC's procedural verification and time-out policy for applicable invasive, surgical, procedural, bedside, and clinic-based procedures.
- Confirm patient identity using approved identifiers.
- Verify the planned procedure, site, side, level, laterality, consent, relevant documentation, imaging, implants, equipment, blood products, specimens, and special requirements before the procedure begins.
- Resolve discrepancies before proceeding.

Do not rely on memory or assumptions. Verification must be active, intentional, and documented according to UTMHC policy.

Key point: Procedural verification starts before the procedure room and continues until the team confirms the correct patient, procedure, site, and required elements immediately before starting.



Site Marking

Site marking is required when the procedure involves laterality, multiple structures, or multiple levels, unless an exception applies under UTMC policy.

Medical staff expectations:

- The attending surgeon or proceduralist who is ultimately responsible for the procedure marks the site.
- The site is marked with the practitioner's initials. Do not use an "X".
- The mark must remain visible after positioning, prepping, and draping.
- The mark should be made with the patient involved when possible.
- Do not mark non-operative sites.
- Resolve any disagreement about site, side, level, documentation, imaging, or consent before the procedure begins.

Examples where site marking may apply include procedures involving right/left distinction, multiple fingers or toes, multiple lesions, spinal levels, or other clearly distinct procedural sites.

Key point: Site marking is a safety confirmation, not a paperwork step. If the site, side, or level is unclear, stop and clarify before proceeding.



Time-Out: Immediately Before the Procedure

A time-out is required immediately before starting the procedure. The time-out must be performed with active participation of the procedural team.

Medical staff expectations:

- The attending surgeon or proceduralist initiates the time-out.
- All other activity stops during the time-out.
- Confirm the correct patient, procedure, site, side, level, and position.
- Confirm that consent matches the planned procedure.
- Confirm required imaging, lab results, blood products, implants, devices, equipment, antibiotics, specimens, and special safety needs when applicable.
- Confirm allergies, anticipated critical events, and patient-specific risks including fire-risk assessment when required by the procedure or policy.
- Ensure all team members have the opportunity to speak up if something does not match or is unclear.
- Do not begin the procedure until discrepancies are resolved.
- When two or more procedures are performed on the same patient and the proceduralist changes, perform a time-out before each procedure
- For a bedside or clinic procedure without sedation, the practitioner conducts the pause with the patient. If the patient cannot participate, another provider, nurse, or medical assistant must be present.

Key point: The time-out must be real, audible, and participatory. The procedure does not start until the team agrees it is safe to proceed.



Documentation and Speaking Up

Medical staff are responsible for supporting a culture where anyone can stop the process when a concern is identified.

Medical staff expectations:

- Document procedural verification, site marking, and time-out completion according to UTMC policy.
- If an inconsistency is identified, stop the procedure process and resolve the discrepancy before proceeding.
- Support team members who speak up about patient identity, consent, site, side, level, laterality, equipment, implant, specimen, or safety concerns.
- Report near misses, wrong-site risks, incorrect consent, missing documentation, or Universal Protocol breakdowns through the UTMC event reporting process.

Key point: A near miss is still a patient safety event. Reporting helps UTMC identify system gaps before harm occurs.

Medical Record Documentation Standards



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Medical Record Documentation Standards

Medical staff documentation must be accurate, timely, complete, legible, authenticated, and consistent with UTMHC policy, Medical Staff Rules and Regulations, patient care needs, and applicable regulatory requirements.

Medical staff documentation should support:

- The patient's condition, assessment, diagnosis, and plan of care.
- Medical necessity for services, procedures, tests, treatment, admission, continued stay, discharge, or transfer.
- Clinical decision-making and response to changes in condition.
- Communication among the care team.
- Patient rights, informed consent, refusal of care, education, and discharge planning.
- Quality review, billing, coding, compliance, and continuity of care.

Medical staff must complete, correct, and authenticate documentation according to required timeframes.

Key point: The medical record should clearly show what was assessed, what was decided, what was done, why it was done, and how the patient responded.



Provider Documentation at Admission, Procedure, and Discharge

Admission — History and Physical

- Complete the inpatient H&P within **24 hours of admission** and before surgery or a procedure requiring anesthesia.
- If using an H&P completed within the preceding **30 days**, examine the patient and document an update within 24 hours of admission/registration and before the procedure.
- For procedures requiring anesthesia, UTMC requires an update **on the day of the procedure** when the H&P was completed earlier.

After Surgery or a High-Risk Procedure

- Complete and authenticate the operative report or brief procedure note **before transfer to the next level of care**, including direct transfer to the ICU.
- For patients recovering in PACU, complete the note **before PACU discharge**.
- Document the diagnoses, procedure, practitioners, findings, anesthesia, estimated blood loss, specimens/implants, and complications, as applicable.
- If using a brief note, complete the detailed operative report within **24 hours**.

Discharge

- Complete the discharge summary at discharge or within **24 hours afterward**.
- Include the reason for hospitalization, significant findings, diagnoses, treatment, discharge condition, and instructions/follow-up.
- The discharging physician must countersign a summary completed by an APP or resident, as required by UTMC policy.

Key point: Document promptly so the next care team has the information needed to continue safe care.



Orders, Verbal Orders, and Authentication

Medical staff orders must be clear, complete, timely, clinically appropriate, and authenticated according to UTMCM policy.

Medical staff expectations:

- Enter orders directly into Epic using approved workflows and order sets.
- Write clear, complete orders. Include the dose, route, frequency, indication, and any necessary monitoring or treatment parameters.
- When ordering multiple PRN medications for the same indication, specify when to use each medication.
- Limit verbal and telephone orders to appropriate situations under UTMCM policy. Ensure the recipient records the order and reads it back for verification.
- **Authenticate verbal and telephone orders promptly, as soon as possible.** UTMCM's policy specifies an outer deadline of 30 days after discharge; this does not replace the expectation for prompt authentication.
- **UTMCM does not permit orders through text messages, email, or Secure Chat.** Enter the order through the approved medical record workflow.
- Review and reconcile orders at transitions of care. Resolve unclear, conflicting, or duplicate orders promptly.

Key point: The order must clearly tell the care team what to do, when to do it, and what to monitor.



Impaired Practitioner Awareness and Support



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Impaired Physician and Practitioner Awareness

- Impairment may affect a physician or practitioner's ability to safely provide patient care.
- Impairment does not only mean substance use. It may include any condition or circumstance that affects judgment, cognition, behavior, communication, physical ability, or clinical performance.
- Examples may include substance use disorder, mental health concerns, physical illness, fatigue, medication effects, cognitive changes, burnout, or other health conditions.
- Medical staff are not expected to diagnose impairment.
- Medical staff are expected to recognize concerning signs, protect patient safety, and report concerns through the appropriate medical staff, peer review, patient safety, or leadership process.
- The goal is to protect patients, support safe practice, preserve a fair process for the practitioner, and connect the practitioner with appropriate evaluation or support when needed.



Impaired Physician and Practitioner Awareness

Possible Warning Signs

Warning signs may be clinical, behavioral, or operational.

A single observation may not confirm impairment, but it may still require escalation if patient safety or safe practice could be affected.

Possible warning signs may include:

- Changes in clinical judgment or decision-making
- Unexplained errors, near misses, or unsafe practice patterns
- Delayed, incomplete, or inaccurate documentation
- Repeated lateness, absences, or lack of availability when on duty or on call
- Behavior changes, inappropriate communication, disruptive conduct, or professionalism concerns
- Confusion, memory concerns, slurred speech, odor of alcohol, impaired coordination, or unusual appearance
- Unusual medication handling, prescribing, wasting, or controlled substance patterns
- Concerns raised by staff, patients, families, or peers



Impaired Physician and Practitioner Awareness When and How to Escalate Concerns

Immediate escalation is required when there is a concern that a practitioner may not be safe to continue patient care.

Concerns should be reported through the appropriate medical staff, peer review, patient safety, leadership, or chain-of-command process.

Follow the medical staff bylaws, rules and regulations, hospital policy, and applicable reporting requirements.

When reporting a concern, focus on objective facts:

- What was observed
- When and where it occurred
- Who was involved or present
- Whether patient care was affected
- Any immediate safety actions taken
- Avoid making assumptions, assigning a diagnosis, or labeling the practitioner as impaired unless that determination has been made through the appropriate review process.



Impaired Physician and Practitioner Awareness

Reporting Responsibility, Confidentiality, and Support Resources

- Medical staff have a professional responsibility to report concerns that may affect patient safety, safe clinical practice, or professional conduct.
- Reports should be timely, factual, made in good faith, and escalated through the appropriate process.
- The purpose of reporting is not punitive. The purpose is to protect patients, support safe practice, and allow the organization to respond appropriately.
- Confidentiality is maintained to the extent allowed by law, medical staff process, peer review protections, hospital policy, and patient safety obligations.
- Confidentiality does not override the hospital's responsibility to protect patients or take immediate action when there is a safety concern.
- Ohio has confidential monitoring resources for eligible impaired practitioners through the State Medical Board of Ohio and OhioPHP. These resources may support eligible practitioners with concerns such as burnout, mental health, substance use disorders, physical illness, or other potentially impairing conditions.
- Confidential monitoring or practitioner support resources do not replace immediate internal escalation when patient safety may be at risk.



End-of-Life and Donation Referral Responsibilities

Organ, Tissue, and Eye Donation: Provider Responsibilities

- **Recognize imminent death early.** For a ventilated patient with a heartbeat, UTMCI referral criteria include a Glasgow Coma Scale score of 5 or less, evaluation for brain death, or consideration of withholding or withdrawing life-sustaining treatment.
- **Notify the bedside nurse and verify the OPO referral.** UTMCI requires notification within 2 hours when imminent-death criteria are met and before life-sustaining treatment is withdrawn. Following cardiopulmonary death, verify that the tissue and eye referral is made within 1 hour.
- **Do not rule out donation based on your own assessment.** The OPO determines donor suitability.
- **Keep care decisions separate from donation.** Continue appropriate treatment and comfort care. Coordinate donation discussions with the OPO and UTMCI's designated process; do not initiate a donation discussion before the decision to withhold or withdraw treatment unless the family raises it.
- **Document** the clinical decisions, discussions, and coordination with the care team and OPO.



UTMC Provider Reference: Where to Find the Current Requirements

Use the UTMC policy site when you need the full procedure or a current policy version:

- [UTMC Policy Directory](#) — Start here to search by topic or policy number.
- [Medical Staff Policies and Bylaws](#) — Privileges, coverage, supervision, consultation, and documentation responsibilities.
- [Hospital Administration Policies](#) — Hospital-wide processes, including patient safety, consent, restraint, EMTALA, and emergency care.
- [Infection Control Policies](#) — Isolation, exposures, reportable diseases, and vascular access.
- [Inpatient Psychiatry Policies](#) — Setting-specific requirements, including restraint and seclusion.

Need an answer during patient care?

- Use the applicable policy and contact the responsible clinical service or on-call leader.
- Escalate an immediate safety concern through the care team without waiting for a policy search.



Attestation and Submission

Please complete the **2026 Medical Staff Onboarding and Annual Education Attestation** after reviewing this education.

Return the completed attestation to the **Medical Staff Office** according to the assigned submission process.

Completion of the attestation confirms that you have reviewed the education and understand your responsibilities as a UTMC medical staff member or credentialed practitioner.

For questions, contact the **Medical Staff Office**.

Thank you for completing the 2026 Medical Staff Onboarding and Annual Education.