

**Aurora Medical Center Grafton, LLC  
Policies Governing Medical Practices**

**Effective November 1, 2010**

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AURORA MEDICAL CENTER GRAFTON, LLC  
GRAFTON, WISCONSIN

MEDICAL STAFF RULES AND REGULATIONS

1. **ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS.**

1.1 Admitting Privileges. Patients may be admitted and treated in this Medical Center only by practitioners who have been appointed to the Medical Staff and granted admitting privileges in accordance with the Medical Staff Bylaws ("Practitioner"). Written criteria shall be developed within each department and section to determine eligibility of such candidates, and will be approved through the credentialing process specified in the Medical Staff Bylaws.

1.2 Definitions of Patient Populations by Age.

Neonate:	Birth through 27 days
Infant:	28 to 364 days
Preschool:	1 <sup>st</sup> year through 5 <sup>th</sup> year
School Age:	6 <sup>th</sup> year through 12 <sup>th</sup> year
Adolescent:	13 <sup>th</sup> year through 17 <sup>th</sup> year
Adult:	18 through 64 years
Geriatric:	65 years and older

1.3 Admitting Practitioner Responsibilities. The admitting Practitioner shall be responsible for giving such information as may be necessary for the welfare of the patient and the Medical Center, including the patient's full name, age, degree of urgency, provisional diagnosis, the existence of any known allergies to food, medications, latex, or other substances, and any known special needs the patient may have, such as need for a translator, or hearing or visual assistive devices. In the case of an emergency, such information shall be recorded as soon as possible but no later than twenty-four (24) hours after the admission of the patient.

For patients who receive urgent or immediate services, the medical record must contain: (1) the time and means of arrival at the Medical Center, (2) any emergency care, treatment and services provided to the patient prior to his/her arrival at the Medical Center (if available); and (3) the time of Practitioner involvement or notification, administration of treatment (including medications), and discharge or transfer from the emergency or urgent care department.

All patients admitted to the Medical Center shall be under the care of a Practitioner designated to be responsible for the medical aspects of care. The admitting Practitioner shall assure that the medical record contains copies of any advance directives.

1.4 Admitting Orders. For each Medical Center inpatient, the medical record must contain an admission order and note ("Admission Order"). Such Admission Order shall contain: (1) a concise statement of patient complaints, including the chief complaint, and the date of onset and duration of each; (2) the reason for admission for care, treatment and services, including the patient's initial diagnosis(is), diagnostic impression(s) or condition(s); (3) treatment goals and plan of care (plans of care and discharge plans should be initiated immediately upon admission and should be modified in the progress notes as patient care needs change); (4) any information related to the patient's condition, including but not limited to alcohol or drug use or mental illness as may be necessary to assure the protection of other patients, Medical Center personnel and Practitioners from patients who may be a source of danger to themselves or others; and (5) the name of the admitting and attending Practitioner. It is the expectation that the attending Practitioner or his or her designated alternate or independent health affiliate will provide the Admission Order to the nursing unit within one (1) hour of a patient's admission. If the attending Practitioner or his or her designated alternate cannot be reached to obtain the Admission Order within one (1) hour of a patient's admission, the patient's care may be turned over to the first available person identified in the hierarchy below to obtain the Admission Order and for all additional care/treatment thereafter.

Hierarchy for Handling Patient Care/Orders  
when both the Practitioner and alternate  
are not available:

- Section Head (if one has been appointed)
- Department Chief
- Practitioner on ER back-up call for the specialty
- President of the Medical Staff
- President-Elect of the Medical Staff

The unavailability of the attending or his or her designated alternate will be brought to the attention of the respective Section Chair or Department Chief by the nursing manager. Failure of a Practitioner to be available for the care of hospitalized patients shall be referred to the Medical Staff Peer Review Committee.

1.5 Psychiatric Admissions. Any psychiatric and substance abuse patients admitted with actual or impending physiological instability will be admitted as a medical patient to an appropriate nursing unit equipped to manage the patient's physiological condition. If the aforementioned patient presents to the Emergency Department, the decision to admit the individual as a medical patient remains the responsibility of the Emergency Department Practitioner in collaboration with the patient's psychiatrist and attending medical Practitioner.

A medically unstable psychiatric patient will remain hospitalized until such time as the patient is medically stable for transfer to an appropriate behavioral health facility. Patient status will be assessed and documented on the medical record with the same frequency delineated for all medical admissions.

Emergency detention of patients with psychiatric diagnoses shall be handled in accordance with the Medical Center Administrative Manual policies for Emergency Detention.

1.6 Admissions to Intensive Care. Admissions to an intensive care unit and transfers to and from an intensive care unit shall be determined in accordance with policies and criteria established by the Medical Executive Committee, or its designated subcommittee.

The attending Practitioner or his/her designated consultant should see a patient within two (2) hours of admission to an intensive care unit.

1.7 Admission Examination and Tests. A routine examination will be made of all patients upon admission. Appropriate admission tests, as determined by the attending Practitioner, shall be performed on each patient admitted to the Medical Center. A preoperative diagnosis will be recorded prior to surgery.

1.8 Admission Agreement and Consent for Treatment. An admission agreement form, giving general consent to Medical Center admission and treatment, shall be signed by the patient or on the patient's behalf by a legally authorized person for each patient admitted to the Medical Center.

In accordance with Aurora Policy on Informed Consent/Informed Refusal, the ordering or performing Practitioner is responsible for obtaining the patient/representative's agreement to proposed treatment. Non-Practitioner staff may provide the patient/representative with written or other information regarding proposed treatment, but the performing Practitioner remains responsible for ensuring that the patient/representative has been adequately informed of risks, benefits and alternatives, and has had an opportunity to ask questions about proposed treatment.

1.9 Patient Transfer.

1.9.1 Transfer of Patient from One Practitioner to Another. If primary responsibility of a patient's care is transferred from one Practitioner to another, this transfer of care shall be recorded in the patient's medical record with an acknowledgment by the receiving Practitioner. The original primary Practitioner may not discontinue responsibility for the care of the patient until the receiving Practitioner has acknowledged and accepted the transfer of responsibility.

1.9.2 Transfer Between Departments in the Medical Center. The attending Practitioner for a patient who becomes medically unstable and requires emergency attention by a member of another Department or specialty is responsible for identifying a Practitioner from the appropriate Department or specialty to whose care the patient can be transferred. If the Practitioner to whom the patient is to be transferred refuses to accept the patient, the patient will be assigned to another Practitioner by the Section Head or Department Chief of the Department into which the patient is being transferred. If the Section Chair or Department Chief is not available, the President of the Medical Staff, or in

the absence of the President, the President-Elect of the Medical Staff, will be responsible. This transfer of care shall be recorded in the patient's medical record. A patient may only be transferred from a post-anesthesia recovery unit to another Medical Center Department upon the recommendation of an anesthesiologist, another qualified Practitioner or a certified registered nurse anesthetist.

1.9.3 Discharge/Transfer from the Medical Center Inpatient/Outpatient Departments. Medical Center patients may be discharged from any Medical Center inpatient or outpatient Department and transported to another non-Medical Center facility by the attending Practitioner in accordance with the procedures set forth in Section 1.10 (Patient Discharge). The attending Practitioner must also ensure that: (1) the receiving facility has the capability to manage the patient's condition; (2) the receiving facility has consented to the admission and appropriate transfer arrangements have been made; (3) the patient is considered sufficiently stabilized for transport; and all pertinent medical information necessary to ensure continuity of care accompanies the patient to the receiving facility (including a Discharge Summary that includes the elements set forth in Section 3.17). The attending Practitioner shall inform all Medicare patients and/or the Medicare patient's family of his or her freedom to choose among Medicare providers and, when possible, respect the Medicare patient's and/or family's preferences when they are expressed.

1.10 Patient Discharge Patients shall be discharged only on the written order of the attending Practitioner or his/her alternate. The physician is not required to see the patient on the day of discharge if he/she has reviewed the record and determined that discharge is appropriate. It shall be the responsibility of the attending Practitioner to discharge his/her patients on the day of discharge at such time as established by the Medical Center. The attending Practitioner and/or appropriate designated personnel shall participate in discharge planning, utilizing the procedures outlined in the Medical Center Discharge Planning Policy. Such procedures shall include: (1) identifying any needs the patient may have for psychological or physical care, treatment and services after discharge or transfer; (2) including the patient, the patient's family, Practitioner, clinical psychologists and other staff involved in the patient's care, treatment and services in planning for the patient's discharge or transfer; (3) assisting in arranging the services required by the patient after discharge in order to meet the patient's ongoing needs for care and services; and (4) provide the patient and the patient representative with information regarding why he or she is being discharged or transferred, any alternatives to discharge or transfer, the types of continuing care, treatment and services the patient will need after the discharge and how to obtain any continuing care, treatment and services that the patient will need. In the absence of finding that a patient needs a discharge plan through screening, the patient's physician may request a discharge plan; in such a case, the hospital will develop a discharge plan for the patient. The attending Practitioner or appropriate advanced practice professional shall write orders for any acute care or skilled services required by the patient in preparation for discharge, and shall complete and sign on a timely basis any mandated or applicable medical information forms so that information necessary to the continuity of care is readily available to the receiving agency or institution. The attending Practitioner



must ensure that the patient or his or her representatives receives appropriate written discharge instructions (including a Discharge Summary that includes the elements set forth in Section 3.17).

1.9.4 Discharge of Infants. An infant may be discharged only to a parent who has lawful custody of the infant, or to an individual who is legally authorized to receive the infant. If the infant is discharged to a legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents. The medical record must include the identity of the legally authorized individual who receives the infant.

1.9.5 Discharge/Transport from the Emergency Department. For standards and documentation requirements relating to patients receiving emergency treatment that are discharged to home or transported to a non-Medical Center facility, refer to the Medical Center's EMTALA Policy.

1.9.6 Objections to Discharge. If a patient objects to discharge from the Medical Center, contact Case Management.

1.9.7 Discharge Against Medical Advice. Should a competent patient leave the Medical Center against the advice of the attending Practitioner or without proper discharge, a notation of the occurrence shall be made in the patient's medical record. The patient must be asked to sign a form acknowledging departure against medical advice and releasing the attending Practitioner and the Medical Center and its employees and officers from all liability that may arise as a consequence. If it is clear that the patient refusing treatment lacks decision-making capacity, it may be necessary to obtain guidance from a court before discontinuing treatment or allowing the patient to refuse treatment or to self-discharge against medical advice. Therefore, in such event, consultation with Medical Center legal counsel should be obtained.

1.10 Patient Death. In the event of a death within the Medical Center, the attending Practitioner shall be promptly notified. Only a physician on the Medical Staff, Coroner, Deputy Coroner, Medical Examiner or Deputy Medical Examiner may legally pronounce death at the Medical Center. Other non-physicians including nurse practitioners, physicians assistants, registered nurses and paramedics may not pronounce death. The body of the deceased shall not be released until an entry has been made and signed in the medical record of the deceased by the attending physician or his or her designee. Release of the body of the deceased shall be in accordance with Medical Center policies and procedures and any applicable local or state regulations.

In the event of a death, which is reportable under statutory requirements to the Medical Examiner, it shall be the responsibility of the attending Practitioner to make such report.

1.11 Organ Donation. Every Practitioner is expected to comply with the Medical Center Organ/Tissue Donation Policy found in the Administrative Manual, in order to facilitate compliance with federal and state legislation requiring that organ

donation requests be made of surviving family members of patients who expire and are suitable candidates for organ donation.

1.12 Autopsy. It shall be the responsibility of all Practitioners to secure written permission for meaningful autopsies whenever possible. If an individual other than the attending Practitioner requests an autopsy, the Practitioner who receives the request must notify the attending Practitioner of the request. Autopsies shall be obtained in accordance with the Medical Center Autopsy Policy, current State regulations as set forth in DHS 135.04(2), and the guidelines established by the Ozaukee County Medical Examiner's Office, and in conjunction with criteria recognized by the College of American Pathologists. When an autopsy is performed, the Medical Staff and, specifically, the Practitioners involved in the patients' care, shall be notified.

These criteria for autopsy are as follows:

1.12.1 Deaths set forth in section 1.14 of these Rules and Regulations. Practitioners must first obtain the written authorization of the Coroner of the county in which the injury or cause of death occurred prior to performing an autopsy or embalming the decedent.

1.12.2 Death in which autopsy may help to explain unknown and unanticipated medical complications to the attending Practitioner;

1.12.3 All deaths in which the cause is not known with certainty on clinical grounds;

1.12.4 Unexpected or unexplained deaths occurring during or following any dental, medical, surgical or diagnostic procedures and/or therapies;

1.12.5 Deaths of patients who have participated in clinical trials (protocols) approved by the institutional review board (IRB);

1.12.6 Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction;

1.12.7 Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as the following: Persons dead on arrival at the Medical Center;

1.12.8 Deaths occurring in the Medical Center within twenty-four (24) hours of admission;

1.12.9 Deaths in which the patient sustained, or apparently sustained, an injury while hospitalized;

1.12.10 Deaths resulting from high-risk infections and contagious diseases;

1.12.11 All obstetrical deaths;

1.12.12 All neonatal deaths;

1.12.13 Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which may have a bearing on survivors or recipients of transplant organs;

1.12.14 Deaths known or suspected to have resulted from environmental or occupational hazards;

1.12.15 Sudden deaths of persons not disabled by recognizable disease processes in which a fracture of a major bone (femur, humerus, tibia) has occurred within the past six months.

An autopsy may be performed only with a written consent signed in accordance with Wisconsin Statutes and current Medical Center policies and procedures. All autopsies shall be performed by a pathologist or by a practitioner delegated this responsibility, e.g. pathology resident or physician's assistant. A provisional anatomic diagnosis shall be recorded in the medical record within two (2) days, and the complete autopsy report shall be placed in the deceased patient's medical record within thirty (30) days.

### 1.13 Reportable Deaths.

1.13.1 Deaths Reportable to Medical Examiner. It is the initial responsibility of the attending Practitioner or designated alternate to report to the Ozaukee County Medical Examiner's Office deaths which occur in the Medical Center, that occur under any of the circumstances listed below, as outlined in the Medical Center Administrative Manual Policy on Reportable Deaths. In the event the attending Practitioner or designated alternate fails to make a timely report, any others with knowledge of the circumstances shall report the death if it occurred under any of the following circumstances:

- All deaths in which there are unexplained, unusual, or suspicious circumstances;
- All suicides;
- All homicides;
- All deaths due to poisoning, whether homicidal, suicidal, or accidental;
- All deaths following accidents, whether the injury was or was not the cause of death;
- When there was no Practitioner or accredited practitioner or accredited practitioner of a bona fide religious

denomination relying on prayer or spiritual means for healing in attendance within 30 days preceding death.

- When the Practitioner caring for the decedent refuses to sign the death certificate;
- When, after reasonable efforts, a Practitioner cannot be obtained to sign the medical certification within six (6) days after the pronouncement of death or sooner under circumstances which the Coroner or Medical Examiner determines to be an emergency; Maternal deaths due to abortion; Deaths of inmates of public institutions, who have not been hospitalized for irreversible dementia;
- Deaths of persons in custody of law enforcement officers;
- Deaths that occur in association with, or as a result of diagnostic, therapeutic, or anesthetic procedures;
- Deaths due to neglect;
- Fetus of twenty (20) weeks or older, unattended by a Practitioner;
- Sudden deaths of persons not disabled by recognizable disease processes, in which a fracture of a major bone (femur, humerus, or tibia) has occurred within the past six (6) months;
- Deaths occurring outside of a hospital or nursing home, or who are not registered with an official hospice program;
- Occupational related deaths attributable entirely or in part to external work place factors;
- Any death in which there is doubt as to whether it is a Medical Examiner's case should be reported and discussed with a Medical Examiner's Investigator;
- Sudden infant death cases, or any unexpected death occurring in infants under the age of two (2) years, under circumstances not explained by a preexisting medical problem.

1.13.2 Other Reportable Deaths. Certain deaths that are reportable to the Coroner/Medical Examiner are also reportable to federal or state agencies. In such circumstances, contact the Medical Center's Risk Manager to ensure compliance with applicable reporting requirements. In addition, contact the Medical Center's Risk Manager whenever there is a question about reporting a patient death.

- *Deaths Related to Restraints and Seclusion*. Any death that occurs: (i) while a patient is restrained or in seclusion; (ii) within twenty-four hours of restraint or seclusion; or

(iii) there is a reasonable cause to believe that a patient's death was related to the use of restraint or seclusion; must be immediately reported to the Medical Center's Risk Manager. Refer to the Medical Center's Restraint and Seclusion policy.

- *Death Related to Psychotropic Medication.* If there is a reasonable cause to believe that a death was related to the use of one or more psychotropic medications, the death must be immediately reported to the Medical Center's Risk Manager.
- *Suicide.* If a death is suspected to result from suicide, the death must be immediately reported to the Medical Examiner and the Medical Center's Risk Manager.
- *Fetal Death: Miscarriage, Stillbirth.* A stillbirth resulting from miscarriage and of a gestational age of twenty (20) weeks or more or weighing 350 grams or more must be reported to the local registrar. In the case of a fetal death, the weight and length of the fetus must be recorded on the delivery record. Refer to applicable Medical Center policies.
- *Fetal Death: Induced Abortion.* All induced abortions (the termination of a uterine pregnancy by a Physician of a woman known by the Physician to be pregnant for a purpose other than to produce a live birth or to remove a dead fetus) performed at the Medical Center must be reported to the Wisconsin Division of Public Health. Refer to applicable Medical Center policies.
- *Death Related to Blood Collection or Transfusion.* All deaths related to blood collection or transfusion must be reported to the Food and Drug Administration.
- *Death Related to Plasmapheresis.* All deaths related to plasmapheresis must be reported to the Food and Drug Administration. Refer to applicable Medical Center policies.

## 2. **GENERAL CONDUCT OF PATIENT CARE.**

2.1 **Medication Use.** All drugs and medications administered to patients shall be those listed in the formulary developed by the Aurora Health Care Pharmacy & Therapeutics Committee and approved by the Medical Executive Committee. If a Practitioner prescribes a drug that is not on the Medical Center formulary, and the Aurora Health Care Pharmacy & Therapeutics Committee has made a decision to automatically substitute a formulary agent for that drug, the approved therapeutic alternative will be provided. If a Practitioner prescribes a drug that is not on

the formulary, and the Aurora Health Care Pharmacy & Therapeutics Committee has not made a decision to automatically substitute a formulary agent, a pharmacist will contact the Practitioner to determine if a formulary agent can be substituted for the ordered drug. If the Practitioner feels the ordered drug is necessary, it will be obtained as a non-formulary item for the patient.

Drugs for Institutional Review Board (IRB) approved clinical investigations that are not listed in the formulary shall be used only if in full accordance with the statements of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Food and Drug Administration, and only after approval by the Aurora Health Care Institutional Review Board (IRB).

For inpatient orders: Unless the number of days or doses is specifically indicated by the prescriber, or there is a policy for a specific drug, inpatient medication orders will be valid indefinitely from the time they are ordered to begin. Policies for specific drugs will be generally based on specific concerns and will be subject to the review and approval of the Aurora Health Care Pharmacy & Therapeutics Committee.

All other diagnostic orders (labs, x-ray, etc.) must be reviewed and renewed after three days, unless otherwise ordered by the attending Practitioner.

For outpatient orders: Unless the number of days is specifically indicated by the prescriber, or there is a policy for a specific drug, medication orders will be valid for one year from the time they are ordered to begin.

Every Practitioner attending patients in the Medical Center shall comply with policies concerning drug use as developed by the Aurora Health Care Pharmacy & Therapeutics Committee. If an unacceptable abbreviation is contained in the Practitioner order, the pharmacist shall contact the Practitioner for clarification before carrying out the order in accordance with the Aurora Health Care Administrative Policy.

2.2 Sample Medications. Medication samples may not be used by inpatients at the Medical Center. Distribution of sample medications in the outpatient/ambulatory areas of the Medical Center must follow the Aurora Health Care policy and procedure for control of sample medications, which includes registration of all sample medications in the pharmacy before being brought into outpatient/ambulatory areas. Such registration is important to ensure that appropriate documentation is in place should a sample medication need to be recalled.

2.3 Patient's Medications from Home. Patient use of medications brought from home is prohibited unless specifically ordered by the attending Practitioner. Following identification of any medications brought from home by the patient, these medications should be returned to the patient's family or significant other to be removed from the Medical Center.

When a Practitioner writes an order for the patient to continue medications from home, it is the responsibility of that Practitioner to approve the orders for each medication and the dosage regimen.

2.4 Continued Hospitalization - Attending Practitioner's Responsibility. The attending Practitioner and/or appropriately credentialed advanced practice professional is required to document in the patient's medical record on an ongoing basis the need for continued hospitalization, the estimated period of time the patient will need to remain in the Medical Center, and plans for care following discharge from the Medical Center care. The medical record must contain progress notes which provide a chronological description of the course and results of care, treatment, and services provided, the patient's progress, and any revisions to the plan of care. Such progress notes shall be entered at the time of observation and shall be sufficient to permit continuity of care and transfer of the patient. Final responsibility for an accurate description of the patient's condition and progress rests with the attending Practitioner.

2.5 Frequency of Patient Attendance. All hospitalized patients will be seen on at least a daily basis by the attending Practitioner, or his or her designee. The physician is not required to see the patient on the day of discharge if he/she has reviewed the record and determined that discharge is appropriate. The attending Practitioner shall document in the progress notes each patient attendance. If a progress note is entered by an allied health professional, applicable Practitioner co-signature requirements, as outlined in Aurora Health Care policy, must be met. Exception: Normal, healthy newborns who remain hospitalized while the mom is recovering will be seen and examined within 24 hours of delivery and do not require daily physician visits beyond the initial physical exam.

2.6 Availability of Practitioner and Alternate. Each Practitioner must assure timely, adequate professional care of his or her patients in the Medical Center by being available and by having available one alternate Practitioner, with at least equivalent clinical privileges at the Medical Center, and with whom prior arrangements have been made. An alternate must be available to care for patients during the admitting Practitioner's absence.

Each Practitioner shall have on file in the Medical Staff Office the name of his or her current alternate. If a Practitioner will be out of town or otherwise unavailable, the name of the alternate who will be assuming responsibility for the care of his or her patients during this absence must be indicated in the medical record of his or her hospitalized patients. In case of a failure to reach a Practitioner and the designated alternate, the first available person identified in the hierarchy below will be contacted and shall have authority to assign the care of the patient to another qualified Practitioner.

Hierarchy for Handling Patient Care  
when both the Practitioner and designated alternate  
are not available:

- Section Head (if one has been appointed)

- Department Chief
- Practitioner On Call for this service in the ED
- President of Medical Staff
- President-Elect of the Medical Staff

The unavailability of the Practitioner and the designated alternate will be reported to the Medical Staff Peer Review Committee as a rule violation.

2.7 Consultations. Any qualified Practitioner may be called for consultation within his or her area of expertise. The attending Practitioner shall be responsible for requesting consultation when indicated and for calling in a qualified consultant. Except when consultation is precluded by emergency circumstances or is otherwise not indicated, consultation with the appropriate specialist should be considered under the following circumstances:

- When the diagnosis is obscure after ordinary diagnostic procedures have been completed
- When there is doubt as to the choice of therapeutic measures to be used
- For high risk patients undergoing major operative procedures
- When requested by the patient or his or her family;
- Where there is question of criminal action.

Consultation guidelines for medical surgical critical care:

The admitting Practitioner must have privileges to treat the patient's preeminent conditions or seek specialty consultation to supplement care. The presence of any one of the following diagnoses indicates that a consultation should be considered with a Practitioner with appropriate privileges for the appropriate organ dysfunction:

- Cardiogenic Shock
- Thrombolytic Therapy
- Acute Myocardial Infarction
- Pulmonary Edema unresponsive to therapy within two (2) hours
- Pregnancy
- Acute Ischemic Stroke
- Hemodynamically significant pulmonary embolus



- Renal Consult for creatinine > 3.0 and/or changing creatinine > 1 mg deciliter per day
- Critical care patients on a ventilator for more than forty-eight (48) hours require a pulmonary consult, unless the attending Practitioner has credentials for ventilator management for more than forty-eight (48) hours.

The presence of the following diagnosis is an indication that a consultation should be considered with a Practitioner with endoscopic privileges and/or appropriate surgical privileges.

- Gastrointestinal Bleeding requiring transfusion of > 1/UPRBC/hour

The presence of the following diagnosis is an indication that consultation should be considered with the appropriate Surgical Specialty:

- Acute Abdomen
- Bowel Obstruction
- Chest Trauma
- Major Bone fracture/dislocation
- Ischemia of extremity threatening limb loss
- Facial injury
- Cervical spine injury
- Intracranial Bleed

The Practitioner requesting the consultation shall identify in the patient's medical record the name of the consultant to be contacted, the reason for the consult and whether the consultation is a STAT request. The Practitioner requesting the consultation shall also be responsible for notifying the consultant of the need for the consultation.

The medical record will contain consultation reports from each consulting Practitioner, including a written opinion by the consultant that reflects, when appropriate, the examination of the patient, review of the patient's medical record, and the consulting Practitioner's recommendations.

2.8 Critical Test Values. To assure that appropriate caregivers are made immediately aware of laboratory, radiology, EKG, echocardiography and all other critical test results which are potentially or immediately life threatening, a system is in place to notify attending Practitioners of critical values. The Practitioner receiving the critical test values will read back the critical lab values back to the caller to verify accuracy.

2.9 Infection Control. Every provider attending patients in the Medical Center shall comply with the Infection Control policies of the Medical Center, including but not limited to those that pertain to universal precautions, prevention of communicable diseases, isolation of patients and/or requirements for obtaining cultures for microbiological studies.

2.10 Code Status. All patients in the Medical Center must have a code status designated in their medical records.

2.11 Restraints and Seclusion. Use of restraints and/or seclusion must be initiated and continued in accordance with the current Medical Center Policy on Restraints & Seclusion.

2.12 Timeliness of Scheduled Services. All providers must be in the procedure room and ready to commence the procedure at the time scheduled. Anesthesiologists must be present no later than fifteen (15) minutes prior to the scheduled start of the procedure.

Any Practitioner performing an outpatient or inpatient procedure at the Medical Center must be present in the procedure room, ready to begin at the time the procedure is scheduled.

2.13 Mechanism for Handling Concerns about Patient Care. If a nurse or other healthcare professional involved in the care of a patient has any reason to doubt or question the care provided to that patient, or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of his or her supervisor who, in turn, may refer the matter to the director in charge of the area. If warranted, this director may bring the matter to the attention of the Chief of the Department within which the practitioner has Clinical Privileges. The Department Chief shall take such action as is deemed warranted by the circumstances.

In the event the Department Chief cannot be reached, the President or Vice President of the Medical Staff may be consulted, in that order. The Medical Staff leader consulted is responsible for proper evaluation of the situation. This Practitioner shall report to the director of the area and the attending physician the evaluation of the patient's condition and action ordered to insure proper care. If there is an inordinate delay in Medical Staff action, the appropriate administrator should be notified promptly.

2.14 Research Protocols. Research involving use of investigational treatments, procedures, and/or medications must be reviewed and approved by the Aurora Health Care Institutional Review Board (IRB) and comply with the policies and procedures set forth by the IRB including informed consent. Copies of the research protocol and informed consent must be included in the patient's medical record.

### 3. MEDICAL RECORDS.

3.1 Components. The medical record must contain information such as notes, records, reports, recordings, images, scans, films, test results, and assessments to: (1) identify the patient; (2) justify admission, treatment and services; (3) justify continued hospitalization; (4) support the diagnosis and condition; (5) document the course of treatment and results accurately; (6) describe the patient's progress; (7) facilitate the continuity of care among health care providers; and (8) describe the patient's response to medications and services. In addition, the medical record must contain complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans, and the patient's response to those activities.

In summary, each medical record should contain the following:

- Accurate patient identification data including the patient's name, address, birth date and gender;
- Any patient-generated information;
- The name and contact information of any legally authorized representative;
- Legal status (if the patient is incapacitated or receiving behavioral health care services);
- Patient's language and communication needs;
- For patients who receive urgent or immediate services, the medical record must contain: (1) the time and means of arrival at the Medical Center, (2) any emergency care, treatment and services provided to the patient prior to his/her arrival at the Medical Center (if available); and (3) the time of physician involvement or notification, administration of treatment (including medications), and discharge or transfer from the emergency or urgent care department;
- An Admission Order shall contain: (1) a concise statement of patient complaints, including the chief complaint, and the date of onset and duration of each; (2) the reason for admission for care, treatment and services, including the patient's initial diagnosis(es), diagnostic impression(s) or condition(s); (3) treatment goals and plan of care (plans of care and discharge plans should be initiated immediately upon admission and should be modified in the progress notes as patient care needs change); (4) any information related to the patient's condition, including but not limited to alcohol or drug use or mental illness as may be necessary to assure the protection of other patients, Medical Center personnel and Practitioners from patients who may be a source of danger to themselves or others; and (5) the name of the admitting and attending Practitioner;

- Any known allergies to food, medication, latex, or other materials;
- Any emergency care provided to the patient prior to arrival;
- Information regarding anatomical gift donations, revocations and refusals;
- A health history containing a description of the present illness, past history of illness and pertinent family and social history;
- Any conclusions or impressions drawn from the physical exam including all positive and negative findings resulting from an inventory of systems;
- All relevant diagnoses established during the course of care including, but not limited to, the provisional diagnosis;
- A definitive final diagnosis expressed in terminology of a recognized system of disease nomenclature;
- Updated treatment goals and plan of care;
- Evidence of known advance directives;
- Evidence of informed consent as required by Medical Center policy;
- All orders including, but not limited to, diagnostic and therapeutic orders;
- Results of all ordered diagnostic and therapeutic procedures and tests;
- All operative reports;
- Any conclusions or impressions drawn from the patient's history and physical;
- All tissue reports;
- The patient's response to care, treatment and services;
- Progress notes that provide a chronological picture of the patient's progress which are sufficient to delineate the course and results of treatment;
- Findings of assessments and reassessments;
- Clinical observations;
- Consultation reports;
- Every medication ordered or prescribed, including dosage strength, dose and route;

- Every medication administered, including the strength, dose and route;
- Any access site for medication, administrative devices used and rate of administration;
- Every adverse drug reaction;
- Every medication dispensed or prescribed for an ambulatory patient or an inpatient at the time of discharge, including strength, dosage and route;
- Any referrals, communications, and patient education provided.
- Any patient generated information;
- A Discharge Summary;
- Ongoing Ambulatory Care Summary;
- Transfer summary (if applicable);
- Discharge plan and discharge planning evaluation;
- As needed to provide care, treatment and services, the medical record must contain entries describing communications with the patient and/or the patient's representatives and any information generated by the patient;
- Autopsy findings when an autopsy is performed.

3.2 Form. Every page included in a medical record must be clearly labeled with the patient's complete name and medical record number. Only those individuals authorized by the Medical Center may make entries into a patient's medical record, and must do so only through the Medical Center's password-protected electronic system, or on Medical Center-approved medical record forms. All handwritten entries must be made with a pen (pencils and felt tip pens are not permitted).

3.3 Legibility. All entries in the medical record must be legible. Orders, progress notes, nursing notes, or other entries in the medical record that are not legible may be misread or misinterpreted and may lead to medical errors or other adverse patient events.

3.4 Treatment Orders Including Verbal Orders. All orders for patient care shall be documented in the medical record. All caregivers utilizing computerized Practitioner order entry (CPOE), as well as written orders, must include their professional credential. Caregivers who do not have privileges to independently issue and authenticate orders, or a particular type of order, must enter the order as a verbal order on behalf of the supervising Practitioner. The supervising Practitioner shall authenticate all verbal and/or telephone orders within forty-eight (48) hours. The following Practitioners may independently issue treatment orders if granted the privileges to do so:

- Licensed Independent Practitioners (MD, DO, DDS, DMD, DPM) with appropriate medical staff privileges;
- Residents (MD or DO) in a formal graduate or post-graduate medical education program approved by Aurora Health Care;
- Physician's Assistant (in accordance with collaborative/supervision agreement with Practitioner);
- Nurse Practitioners (in accordance with collaborative/supervision agreement with Practitioner);
- Clinical Nurse Specialists (in accordance with collaborative/supervision agreement with Practitioner).

Verbal and telephone orders are to be reserved for urgent and emergent situations. All verbal or telephone orders must be read back to the Practitioner giving the order to verify accuracy.

Verbal (face-to-face) orders are not acceptable except in the case of an emergent situation.

Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). A licensed respiratory care practitioner (RCP), registered dietician, speech therapist, physical therapist, occupational therapist, radiology technician, or a registered pharmacist (RPH) may accept verbal orders, provided the orders are directly related to their specialized discipline.

3.5 Date, Time, Authentication and Co-Signature. All medical record entries must be dated, timed (using military time), and authenticated (by written signature, identifiable initials, computer key, or other code) by the individual who made the entry. All entries must be made as soon as possible after an event or observation is made. An entry may not be made in advance, and it is not acceptable to pre-date or back-date a medical record entry. If it is necessary to summarize events that occurred over a period of time (such as an entire shift), the entry should indicate the actual time the entry was made with the narrative documentation identifying the time certain events occurred.

The use of electronic signature or code is only acceptable if the individual has an attestation statement on file in the Medical Records Department acknowledging that he or she is the only individual authorized to use the electronic signature or code. Delegation of an electronic signature or authentication code to another individual is prohibited. A medical record entry may not be authenticated by use of a rubber stamp signature.

In certain circumstances, medical record entries must be co-signed by a Practitioner. These circumstances include certain entries by a Practitioner-employed or sponsored Clinical Assistant or Advanced Practice Professional, and certain entries made by a Dentist, Oral Surgeon or Podiatrist. The co-signing Practitioner is responsible

for the content of the medical record entry. A complete listing of the current co-signature requirements are posted on the Aurora intranet website for Compliance & Ethics.

When a non-physician provider is entering an order in the medical record, he/she must properly identify himself/herself in the record by professional credential. When a co-signature is required by Aurora co-signature guidelines, the non-physician provider will document the order as a verbal order. The non-physician provider will indicate by first name, last name and IDX number, the co-signing Practitioner, followed by the first name, last name and IDX number of the non-physician provider.

3.6 Late Entries. When a medical record entry was missed or not entered into the medical record in a timely manner, a late entry should be used to record the information in the medical record. Such late entry shall:

- Identify the new entry as a "late entry";
- Contain the current date and time, so as not to give the impression that the entry was made on an earlier date or an earlier time;
- Identify or refer to the date and time (if known) of the incident for which the late entry is written;
- If used to document an omission, validate the source of additional information as much as possible (for example: use of supporting documentation on other Medical Center worksheets or forms);
- Be recorded as soon as possible.

3.7 Completeness/Timeframe for Completion. All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to: (1) identify the patient; (2) support the diagnosis/condition; (3) justify the care, treatment, and services provided; (4) document the course and results of care, treatment, and services; and (5) promote continuity of care among caregivers.

It is the responsibility of the attending Practitioner to complete all medical records within twenty-one (21) days of the patient's discharge.

3.8 Excessive Medical Record Deficiency. Chronic failure to complete records in a timely fashion will result in corrective action, and may result in loss of Medical Staff membership and Clinical Privileges, pursuant to the Medical Staff Bylaws. Practitioners who have an excessive number of incomplete medical records may be prohibited from scheduling elective procedures until such time as the incomplete records are completed.

3.9 Symbols and Abbreviations. A list of unacceptable abbreviations, acronyms, symbols and dose designations shall be identified and approved by the Medical Executive Committee. An official record of such list is available at each nursing station.

Only those symbols, abbreviations, acronyms and dose designations not on such list may be used.

3.10 Informed Consent or Refusal. The medical record must contain documentation of informed consent or refusal, including documentation of circumstances when a patient leaves the facility against medical advice, in accordance with the Aurora Health Care Informed Consent/Informed Refusal Policy.

3.11 History and Physical Examinations. The purpose of a medical history and physical examination (H&P) is to determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient.

At a minimum, the history and physical examination report must include the patient's: (1) chief complaint; (2) details of the present illness; (3) relevant past medical, social and family histories (including past response to treatment, known allergies, current medications and dosages); (4) emotional, behavioral and social status when appropriate; and (5) all pertinent findings, conclusions and impressions resulting from a comprehensive, current assessment of all body systems.

Inpatients. The Practitioner who is responsible for the care and treatment of the patient during the patient's inpatient stay is responsible for ensuring that an H&P is performed, documented, and authenticated for each Medical Center inpatient: (a) prior to any non-emergent surgery, or any inpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours of the patient's admission, whichever occurs first.

Outpatients. If a Medical Center outpatient will undergo a surgical or other procedure requiring anesthesia services (other than local anesthesia), the Practitioner who is responsible for the care and treatment of the patient during the patient's outpatient stay is responsible for ensuring that an H&P is performed, documented, and authenticated prior to any non-emergent surgery, or any outpatient procedure requiring anesthesia services (other than local anesthesia). If a Medical Center outpatient will undergo a surgical or other procedure requiring local anesthesia, a full H&P is not required, however the medical record shall document the following prior to procedure: (a) Diagnosis/Indication for procedure (This may be documented in the order), (b) Any comorbid conditions that would affect the course of the patient's treatment or require additional interventions to reduce the risk to the patient.

Emergency Services. If, due to an emergency, it is not possible to complete a pre-procedure H&P, the performing Practitioner shall, at a minimum, enter a notation describing the emergency and any available information relevant to the care of the patient, including but not limited to the patient's vital signs, available history and clinical and status. A complete H&P shall be performed and recorded as soon as possible.



Pre-Admission H&Ps and Updates. An H&P performed by a qualified Licensed Independent Practitioner (LIP) or qualified Advanced Practice Professional (APP) no more than thirty (30) days prior to the patient's admission or registration may be used (even if such pre-admission H&P is performed by a provider who is not a privileged LIP or APP; however, when a pre-admission/registration H&P is used, a qualified LIP or qualified APP must complete and document an updated examination of the patient, including any changes in the patient's condition that may be significant for the planned course of treatment. The qualified LIP or qualified APP shall use his/her clinical judgment, based upon his/her assessment of the patient's condition and co-morbidities (if any), in relation to the patient's planned course of treatment, to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record. If, upon examination, the LIP or APP finds no change in the patient's condition since the pre-admission H&P was completed, he/she may indicate in the patient's medical record that the pre-admission H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the pre-admission H&P was completed. The updated H&P examination must be completed and documented in the patient's medical record: (a) prior to any non-emergent surgery, or any inpatient or outpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours after the patient's inpatient admission or outpatient registration, whichever occurs first.

Multiple Participants. More than one qualified Practitioner may participate in performing, documenting, and authenticating an H&P for a single patient. When performance, documentation, and authentication are shared among qualified practitioners, the Practitioner who authenticates the H&P will be held responsible for its contents.

3.12 Pre-Procedure Documentation. The following pre-procedure documentation shall be present on the medical record prior to any surgery or high-risk procedure, and/or administration of moderate or deep sedation or anesthesia (e.g., any procedure requiring written informed consent).

- History & physical exam
- Patient's written informed consent
- Consultation reports
- Results of all required laboratory, EKG and x-ray studies. In most instances, laboratory, EKG and x-ray results are acceptable if they have been obtained within thirty (30) days prior to the procedure, however, it may be necessary to obtain certain imaging or laboratory results within shorter time periods (e.g., pregnancy tests must be performed immediately prior to surgery, and coagulation tests should be performed as close to the date of surgery as possible).

3.13 Procedure (Operative) Report. The performing Practitioner must either:

Enter or dictate a full procedure report immediately after the procedure and before the patient is transferred to the next level of care (e.g, the patient leaves the recovery room); **or** accompany the patient from the procedure room to the next unit or area of care, and enter or dictate a full procedure report in the new unit or area of care.

The full procedure report must be signed by the performing Practitioner and must include the following information:

- Date and time of the procedure;
- Pre-procedure diagnosis;
- Type of anesthesia administered;
- Name and description of the specific procedure performed;
- Name(s) of performing Practitioner and any individual(s) who performed a significant surgical task during the procedure (even when performing those tasks under supervision).
- A description of techniques, findings, and tissues removed or altered;
- As applicable: estimated blood loss, specimens removed, complications, prosthetic devices, grafts, tissues, transplants, or implants (tissue or devices); and
- Post-procedure diagnosis.

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

3.14 Post-Procedure Documentation. It is the responsibility of the performing Practitioner to assure that the medical record contains the following post-procedure documentation:

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

3.15 Discharge From Post-Procedural Observation. If the patient is admitted and subsequently discharged from a post-sedation or post-anesthesia care area,

the medical record must contain the name of the Practitioner responsible for the discharge, and documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the responsible Practitioner or by another individual in accordance with established discharge criteria.

3.16 Anesthesia Evaluations and Reports. An anesthesia provider must ensure that the following evaluations/reports are properly documented in the medical record:

3.16.1 Pre-Procedure Evaluation. The medical record must contain a pre-anesthesia evaluation, including at minimum: (a) information regarding the choice of anesthesia and the procedure anticipated, (b) the patient's previous medication and anesthetic history, (c) potential anesthetic problems, (d) ASA patient status and classification, and (e) orders for preoperative medications.

3.16.2 Pre-Induction Re-evaluation. The anesthesia provider shall conduct and document a re-evaluation immediately prior to induction.

3.16.3 Intra-operative Report. The anesthesia provider shall complete an intraoperative report, which shall include at minimum: (a) the name of the profession of the Practitioner who administered the anesthesia, the supervising anesthesiologist (if applicable) and the performing Practitioner, (b) name, dosage, route and time of administration of all drugs and anesthesia agents, (c) type, route and amount of IV fluids administered, (d) blood or blood products administered (if applicable), (e) mechanism of oxygenation, flow rate, and pulse oximetry readings, (f) continuous recordings of patient status, including blood pressure, heart and respiration rate, and (g) any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

3.16.4 Post-Procedure Evaluation. Within four (4) to forty-eight (48) hours after a procedure, a post-anesthetic follow-up examination must be completed and documented in the medical record by a Practitioner who is authorized to administer anesthesia.

3.17 Discharge Summary. The attending Practitioner is responsible for ensuring that a Discharge Summary is entered or dictated within fourteen (14) days after discharge. If the Discharge Summary is dictated more than twenty-four (24) hours prior to the patient's actual discharge, the attending Practitioner must ensure the Discharge Summary is updated as necessary. The Discharge Summary should include the following:

- Date of Discharge
- Definitive final diagnosis(es) expressed in a terminology of a recognized system of disease nomenclature;

- Reasons for the patient's admission/registration and transfer or discharge;
- Significant findings and complications, if any;
- Procedures performed;
- Summary of the care, treatment and services provided (including the procedures performed, treatments rendered, the outcome(s) of such procedures and treatments and progress toward goals);
- The patient's condition and disposition of the patient upon discharge (including the patient's physical or psychological status) stated in a manner that allows specific comparison to the patient's condition upon admission/registration;
- The method of transport (if any);
- Provisions for follow-up care (including any appointments following discharge, how patient care needs are to be met following discharge, plans for care by providers such as home health, hospice, nursing homes or assisted living facilities and community resources or referrals made or provided to the patient); and
- Any other specific instructions given to the patient and/or the patient's representatives upon discharge.

3.17.1 Normal Newborn Combined Summary and Assessment (H &P)

A single, combined note that contains all required elements of an admission H&P and Discharge Summary for any newborn that meets the definition of a “normal newborn” is acceptable. Normal newborn is defined as:

A healthy newborn who does not require a second physician examination. The final decision of the health of the newborn is the physician's clinical judgment. However, the following criteria should apply:

- 1 - 37 or greater weeks gestational age.
- 2 - May have been delivered via cesarean section or vaginally with or without instrumentation.
- 3 - Normal vital signs on day of discharge.
- 4 - Normal glucose homeostasis.
- 5 - Normal pulse oximetry screening (if done).
- 6 - Normal feeding, stooling and voiding patterns.
- 7 - Appropriate screening and management of jaundice.

8 - Appropriate parent/guardian disposition and follow up physician identified.

3.18 Anatomical Gifts. The medical record must contain documentation of any anatomical gifts, including (a) the name and title of the person who requests the anatomical gift; (b) the name of the individual who provided consent for the anatomical gift; (c) the consenting individual's relationship to the patient; (d) the response to the request for an anatomical gift; and (e) if a determination is made that a request should not be made, the basis for that determination.

3.19 Maternity and Newborn Records. Except in an emergency, before a maternity patient may be admitted, the patient's attending Practitioner must submit a legible copy of the prenatal history to the Medical Center's obstetrical staff. The prenatal history shall note complications, Rh determination, and any other matters essential to adequate care of the patient and the newborn.

Each newborn infant shall have a complete Medical Center record which shall include:

- A record of pertinent maternal data, type of labor and delivery, and condition of the infant at birth;
- A record of physical examinations;
- A progress sheet recording medicines and treatments, weights, feedings and temperatures;
- The notes of any medical consultant.

In the case of a fetal death, the weight and length of the fetus shall be recorded on the delivery record.

3.20 Pathology Reports. The medical record must contain all pathology reports, including reports of microscopic findings (if any). If only macroscopic examination is warranted, the medical record must contain a statement that the tissue has been received and a macroscopic description of the findings provided by the laboratory.

3.21 Electrocardiographic Strips and Reports. Electrocardiographic strips and reports shall be filed as a permanent record in the patient's medical record. The attending Practitioner may retain a duplicate of the electrocardiographic strips and reports if so requested, but the original recordings shall remain in the patient's medical record at the Medical Center.

3.22 Restraints and Seclusion. The medical record must contain required documentation regarding the use of restraints or seclusion, as specified in the Medical Center's Restraint & Seclusion Policy.

3.23 Adverse Events. The medical record must contain a complete and accurate description of any adverse event (e.g, accidents, complications, Medical Center-acquired infections, unfavorable reactions to drugs or anesthesia, falls, etc.).

3.24 Ongoing Ambulatory Care Services. For each patient who receives ongoing ambulatory care services, the medical record must contain a summary list that includes the following:

- Any significant medical diagnoses and conditions;
- Any significant operative and invasive procedures;
- Any adverse or allergic drug reactions; and
- Any current medications, over-the-counter medications, and/or herbal preparations.

The summary list is updated whenever there is a change in diagnosis, medications, or allergies to medications, and whenever a procedure is performed.

3.25 Closure of Incomplete Medical Records. Medical records shall not be deemed complete until all required documentation and signatures have been completed by the responsible Practitioner. In the rare instance when the record cannot be completed by the responsible Practitioner, it may be closed on the authority of the Medical Executive Committee.

3.26 Release of Medical Records. Written authorization of the patient, or, where applicable, of the next of kin or legal guardian of the patient shall be required for release of medical information to persons not otherwise authorized to receive this information. Any and all requests for copies of medical records should be directed to the Medical Records Department.

3.27 Removal of Records from Medical Center. All medical records are the property of the Medical Center and may not be removed from the institution without the permission of the Administrator or his duly authorized agent. Such permission may only be granted upon agreement of the patient or legal guardian of the patient or by court order, subpoena or statute.

3.28 Patient Confidentiality. It is the policy of the Medical Center and the Medical Staff to maintain medical records in a manner that preserves confidentiality of patient health information.

All Practitioners and Medical Affiliates agree to comply with Aurora Health Care policies and procedures governing the use and disclosure of patient health information (commonly referred to as "Protected Health Information" or "PHI"), as may be amended from time to time.

The Medical Staff and Medical Affiliates participate in an organized arrangement with Aurora Health Care, Inc. ("Aurora"). Participation means the

Medical Staff and Medical Affiliates agree, when present at an Aurora Facility, to abide by the privacy policies and practices as outlined in Aurora's Notice of Privacy Practice. Participation also means such notice, when provided to the patient with the patient's acknowledgment (unless an exception applies), meets federal notice requirements for both the Practitioner and Aurora for care provided at an Aurora facility.

Inappropriate use and disclosure of Protected Health Information will subject the Practitioner to corrective action as outlined in the Medical Staff Bylaws.

4. **OPERATIVE AND INVASIVE PROCEDURES.**

4.1 Anesthesia means the administration (in any setting, by any route, for any purpose) of general, spinal, or other major regional anesthesia or sedation, with or without analgesia, for which there is the exception that, in the manner used, the sedation or analgesia will result in the loss of protective reflexes.

4.2 Operative and Invasive Procedures means procedures involving the puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to any procedures performed in the operating room, any procedure in which moderate or deep sedation or anesthesia is used, or any of the following, even if sedation is not used:

- Abdominal and/or intrathoracic biopsy/aspiration
- Angioplasties
- Blood transfusions
- Cardiac ablations
- Cardiac and vascular catheterizations
- Cardioversion
- Central line insertions (involving primary entry into a major vessel)
- Defibrillation
- Electrophysiology studies
- Endoscopies
- Implantations
- Insertion of chest tube
- Interventional radiology procedures
- Pacemakers
- Percutaneous aspirations and biopsies
- Therapeutic nerve blocks

- Transesophageal echocardiogram (TEE)

Excluded are venipuncture, injectable drug therapy, injection of radiographic contrast media, and peripherally inserted central catheter (PICC) lines.

4.3 Time-Out. In accordance with Aurora Health Care Policy, a time-out will be taken just before starting all operative and other invasive procedures. The "time-out" must be conducted in the location where the procedure will be done. It must involve the entire operative/procedure team. The "time-out" must be documented in the medical record and must include: correct patient identity, correct procedure, correct site and side (Left or right, spine location, finger or toe, etc), correct patient position, availability of correct implants, radiographs, and any special equipment or special requirements.

4.4 Surgical Site Marking. Marking of the surgical site shall be performed in accordance with Aurora Universal Protocol For Prevention.

Site marking applies to procedure where there is more than one possible location for a procedure. Examples are:

- Limbs.
- Fingers
- Toes
- Lesions
- Levels of spine
- Organs

The procedure site is marked before the procedure is performed and if possible, with the patient involved. If the patient refuses marking, document such in medical record and proceed with the procedure.

The procedure site is marked by a licensed independent practitioner (LIP) who is accountable for the procedure and is present when the procedure is performed.

In LIMITED circumstances (i.e., rare instances when it is not feasible for the person responsible for the procedure to mark the site), the LIP may delegate site marking to an individual who has the following qualifications:

- a. A medical resident who is being supervised by the person performing the procedure, is familiar with the patient, and will be present when the procedure is performed.
- b. An Advanced Practice RN or Physician Assistant who has a collaborative agreement or supervisory agreement with the LIP performing the procedure who is familiar with the patient, and will be present when the procedure is performed.



4.5 Specimens. Specimens removed during an operative or invasive procedure shall be handled in accordance with Medical Center policy.

5. **GENERAL MEDICAL STAFF MATTERS.**

5.1 Emergency Preparedness Responsibilities. Each Practitioner shall accept assignments and carry out his or her responsibilities in accordance with established emergency preparedness plans and participate in all drills required by the emergency preparedness plans.

No Practitioner will perform any duties other than those assigned during a disaster.

All Practitioners on the Medical Staff should understand that the circumstances of a particular disaster may necessitate them having to relinquish direction of professional care of their patients to the Practitioner in charge of the overall medical direction of the emergency preparedness plan. This would include, but not necessarily be limited to, cases of evacuation of patients from one section of the Medical Center to another or from the hospital premises entirely.

All policies concerning patient care during a disaster will be the joint responsibility of the Practitioner in charge and the Administrator of the Medical Center, or in their absence, their designee.

5.2 On Call Response Time. In order to assure timely medical care to patients presenting in the Emergency Department, Practitioners providing on-call backup must respond within twenty (20) minutes of being contacted by the Emergency Department. If the Practitioner on call is requested by the Emergency Room to treat an unstable patient, the on-call Practitioner shall report to the Medical Center within a mutually agreed upon time period of being requested to do so.

5.3 Failure to Respond. Practitioners who fail to accept or fulfill their obligations for ER back-up call shall be referred to the Medical Staff Peer Review Committee.

5.4 Personnel Authorized to Perform Medical Screening Examinations. Practitioners and mid-level providers are authorized to perform medical screening examinations for emergency medical conditions.

A registered nurse who has established competencies in OB triage protocols may perform the medical screening examination for specific presenting complaints.

In the Emergency Department, a registered nurse who has established competency in medical staff protocols may perform the medical screening examination for specific presenting complaints, as outlined in the Emergency Department Policy-Registered Nurse Medical Screening Exams.

6. **OTHER PROVISIONS.**

6.1 Adoption. These Medical Staff Rules and Regulations shall be subject to adoption procedures set forth in the Medical Staff Bylaws.

6.2 Amendment Process. Amendments of these Rules and Regulations shall be in accordance with the process set forth in the Medical Staff Bylaws.

6.3 Effective Date. Any amendments to these Medical Staff Rules and Regulations adopted and approved by the amendment process outlined in the Medical Staff Bylaws shall become effective only when approved by the Aurora Medical Center Grafton's Board of Managers.

BOARD APPROVED AND REVISED 06/17/11, 08/17/11, 09/19/11, 07/15/13, 03/20/14, 1/4/2016