



**Metro Medical Staff  
Policies Governing Medical Practices**

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# TABLE OF CONTENTS

<b>Section 1. Admission and Discharge of Patients .....</b>	<b>1</b>
(a) Admitting Privileges.....	1
(b) Definitions of Patient Populations by Age .....	1
(c) Order of Priorities for Admissions .....	1
(d) Admitting Practitioner Responsibilities .....	2
(e) Admitting Orders.....	2
(f) Assignment of Emergency Patients .....	2
(g) Psychiatric Admissions .....	3
(h) Admissions to Special Care Units .....	3
(i) Admission Examination and Tests .....	3
(j) Admission Agreement and Consent for Treatment .....	3
(k) Who Can Write Orders.....	3
(l) Patient Discharge.....	4
(m) Patient Death .....	4
(n) Organ Donation .....	5
(o) Autopsy .....	5
(p) Reportable Deaths .....	6
<b>Section 2. General Conduct of Patient Care.....</b>	<b>7</b>
(a) Medication Use.....	7
(b) Sample Medications .....	8
(c) Patient's Medications from Home .....	8
(d) Continued Hospitalization - Attending Physician's Responsibilities.....	9
(e) Frequency of Patient Attendance.....	9
(f) Availability of Practitioner and Alternate .....	9
(g) Consultations .....	10
(h) Transfer of Patient from One Physician to Another .....	10
(i) Critical Lab Values.....	11
(j) Infection Control .....	11
(k) Code Status.....	11
(l) Restraints and Seclusion.....	11
(m) Timeliness of Scheduled Services.....	11
(n) Mechanism for Handling Concerns about Patient Care .....	11
(o) Research Protocols .....	12

<b>Section 3. Medical Records</b> .....	12
(a) Components.....	12
(b) Treatment and Verbal and Telephone Orders .....	13
(c) History and Physical Examinations.....	14
(d) Preoperative Diagnosis.....	18
(e) Operative Reports.....	18
(f) Progress Notes and Frequency .....	19
(g) Clinical Entries.....	19
(h) Consultation Reports.....	19
(i) Discharge Summaries.....	19
(j) Use of Rubber Stamp .....	20
(k) Symbols and Abbreviations.....	20
(l) Completeness, Legibility, and Pertinence of Medical Records .....	20
(m) Timeframe for Record Completion and Sanctions for Delinquency .....	20
(n) Permanent Filing of Records.....	22
(o) Release of Medical Records.....	22
(p) Removal of Records from Medical Center.....	22
(q) Readmission, Access to Previous Records.....	22
(r) Access to Records for Clinical Investigation/Research.....	22
(s) Patient Confidentiality.....	22
<b>Section 4. Operative and Invasive Procedures</b> .....	23
(a) Anesthesia .....	23
(b) Surgery.....	23
(c) Informed Consent.....	23
(d) Time Out.....	24
<b>Section 5. General Medical Staff Matters</b> .....	24
(a) Medical Staff Dues .....	24
(b) Emergency Preparedness Responsibilities .....	25
(c) On-Call Response Time .....	25
(d) Failure to Respond to ER Back-up.....	25
(e) Personnel Authorized to Perform Medical Screening Exams .....	25
<b>Section 6. Other Provisions</b> .....	26
(a) Confirmation of Immunities, Releases and Confidentiality .....	26
(b) Construction .....	26
(c) Distribution.....	27

**AURORA METRO MEDICAL STAFF**  
**POLICIES GOVERNING MEDICAL PRACTICES**

**Section 1. Admission and Discharge of Patients.**

(a) **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. Patients of mid-wives will be admitted under their sponsoring physician. 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.

(b) **Definitions of Patient Populations by Age.**

Neonate:	Birth through 27 days
Infant:	28 to 364 days
Preschool:	1 <sup>st</sup> year through 5th 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

(c) **Order of Priorities for Admissions.** The following order of priority will be used for the admission of patients.

(i) **Emergency Admission.** Admission of a patient whose condition is such that probable serious harm will occur to the patient if intervention is not initiated and the patient is not admitted within twenty-four (24) hours or less.

(ii) **Urgent Admission.** Admission of a patient with an acute, but not life or limb threatening condition, evaluated as stable but requiring therapeutic intervention within forty-eight (48) hours or less.

(iii) **Preoperative Admission.** Admission of a patient already scheduled for surgery. If it is not possible to handle all such admissions, the Chief(s) of the appropriate departments may decide the urgency of any specific admission.

(iv) **Routine Admission.** Elective admission involving all services.

(v) **Observational Care Admission.** An admission initiated when the attending practitioner needs an extended time to evaluate an outpatient's medical condition in order to determine the need for inpatient admission. An observational care admission permits high intensity service for a short duration of time, generally less

than forty-eight (48) hours. Observation status is based on specific criteria.

The Medical Staff shall define any other categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review of these priorities. All such categories and criteria shall be approved by the Medical Executive Committee.

- (d) **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 hospital, including the patient's full name, age, degree of urgency, provisional diagnosis, 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.

All patients admitted to the Medical Center shall be under the care of a physician, dentist, or podiatrist, with a physician designated to be responsible for the medical aspects of care.

- (e) **Admitting Orders.** The attending practitioner or his or her designated alternate must provide admitting orders to the nursing unit within one (1) hour of a patient's admission. At least two different people will try to reach the attending or his or her designated alternate to obtain admission orders. These attempts will be documented in the patient's record. If the attending practitioner or his or her designated alternate cannot be reached to obtain orders within one (1) hour of a patient's admission, the patient's care will be turned over to the first available person identified in the hierarchy below to obtain these orders and for all additional care/treatment thereafter.

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

- Section Chair
- Service Chief (or Acting Service Chief)
- Physician On Call for this service in the ED
- President of the Medical Staff (or Acting President of the Medical Staff)
- Administrator.

The unavailability of the attending or his or her designated alternate will be brought to the attention of the respective Section Chair or Service Chief by the respective nursing manager. The Section Chair or Service Chief will meet with the practitioner to discuss this matter. Any repeat occurrences will be considered for disciplinary action in accordance with the Medical Staff Bylaws.

- (f) **Assignment of Emergency Patients.** Emergency patients applying for admission, who have no attending physician or dentist shall be assigned to members of the Medical Staff

according to developed protocols, including assignment by Service Chiefs, as set forth in the Medical Staff Bylaws.

- (g) **Psychiatric Admissions.** Any psychiatric patient 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 physician in collaboration with the patient's psychiatrist and attending medical physician.

A physiologically unstable patient will remain hospitalized as a medical patient for the period of time required to assure stability. 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.

- (h) **Admissions to Special Care Units.** Admissions to the special care units (intensive care unit, coronary care unit, cardiovascular intensive care unit) and transfers to and from special care units shall be determined in accordance with policies and criteria established by the Critical Care Committee.

The attending practitioner or his or her designated consultant must see a patient within two (2) hours of admission to a critical care unit.

- (i) **Admission Examination and Tests.** A routine examination will be made of all patients upon admission. Appropriate admission tests, as determined by the attending physician, shall be performed on each patient admitted to the hospital. A preoperative diagnosis will be recorded prior to surgery.
- (j) **Admission Agreement and Consent for Treatment.** An admission agreement form, giving general consent to hospital 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 hospital.

The physician is responsible for discussing procedure/treatment alternatives with the patient and for obtaining an informed consent for specific procedures or treatments, including a consent for surgery signed by the patient or his or her legal representative and in accordance with current Medical Center Administrative Manual policies for consents.

- (k) **Who can Write Orders.** In addition to members of the Medical Staff, the following practitioners can issue orders if authorized by the Medical Executive Committee to do so:
- Residents in Graduate Medical Education Programs (M.D., D.O.)
  - Fellows in Medical Education Programs (M.D., D.O.)

- Advanced Practice Nurse Prescriber
- Anesthesiologist Assistant
- Clinical Nurse Specialist
- Certified Nurse Registered Nurse Anesthetist
- Physician's Assistant
- Nurse Practitioner
- Certified Nurse Midwives
- Registered Dieticians (limited to therapeutic diet orders)
- A licensed speech therapist (limited to the advancement or downgrading within a patient's diet order)

- (l) **Patient Discharge.** Patients shall be discharged only on the written order of the attending practitioner or his or her alternate. It shall be the responsibility of the attending practitioner to discharge his or her patients on the day of discharge at such time as established by the Medical Center. 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 or appropriate designated personnel shall participate in discharge planning, utilizing the procedures outlined in the Medical Center Discharge Planning Policy. The attending practitioner or appropriate designated personnel 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 may request a discharge planning evaluation, and the Medical Center will perform the evaluation upon request.

Should a competent patient leave the hospital 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 hospital counsel should be obtained.

- (m) **Patient Death.** In the event of a death within the Medical Center, the attending physician shall be promptly notified. The deceased patient shall be pronounced dead as soon as time reasonably allows by the attending practitioner, his or her designee, or by any other available physician. 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 practitioner 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. When a hospitalized patient dies, it is the responsibility of the attending physician at the

time of death to sign the death certificate. When another physician is covering for the attending physician at the time of death, it is the covering physician's responsibility to sign the certificate. Exceptions to this rule include cases referred to the Medical Examiner's office, as well as cases where another physician agrees to sign the certificate because of familiarity with the patient.

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.

- (n) **Organ Donation.** Every member of the Medical Staff 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.
- (o) **Autopsy.** It shall be the responsibility of all Medical Staff members to be actively interested in securing written permission for meaningful autopsies whenever possible. Autopsies shall be obtained in accordance with the System Autopsy Policy #96, current State regulations as set forth in HSS 135.04(2), and the guidelines established by the Milwaukee County Medical Examiner's Office, and in conjunction with criteria recognized by the College of American Pathologists.

These criteria for autopsy are as follows:

- (i) Death in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;
- (ii) All deaths in which the cause is not known with certainty on clinical grounds;
- (iii) Unexpected or unexplained deaths occurring during or following any dental, medical, surgical or diagnostic procedures and/or therapies;
- (iv) Deaths of patients who have participated in clinical trials (protocols) approved by the institutional review board (IRB);
- (v) Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction;
- (vi) Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as the following: Persons dead on arrival at the hospital; Deaths occurring in the hospital within 24 hours of admission; Deaths in which the patient sustained, or apparently sustained, an injury while hospitalized;
- (vii) Deaths resulting from high-risk infections and contagious diseases;
- (viii) All obstetrical deaths;



- (ix) All neonatal deaths;
- (x) 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;
- (xi) Deaths known or suspected to have resulted from environmental or occupational hazards;
- (xii) 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.

- (p) **Reportable Deaths.** It is the initial responsibility of the attending physician or designated alternate to report to the Milwaukee County Medical Examiner's Office deaths which occur in the hospital, 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 physician 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:

- (i) All deaths in which there are unexplained, unusual, or suspicious circumstances;
- (ii) All suicides;
- (iii) All homicides;
- (iv) All deaths due to poisoning, whether homicidal, suicidal, or accidental;
- (v) All deaths following accidents, whether the injury was or was not the cause of death;
- (vi) When there was no physician or accredited practitioner who attended or treated the decedent within thirty (30) days preceding death;
- (vii) When the physician caring for the decedent refuses to sign the death certificate;
- (viii) Maternal deaths due to abortion;

- (ix) Deaths of inmates of public institutions, who have not been hospitalized for irreversible dementia;
- (x) Deaths of persons in custody of law enforcement officers;
- (xi) Deaths that occur in association with, or as a result of diagnostic, therapeutic, or anesthetic procedures;
- (xii) Deaths due to neglect;
- (xiii) Fetus of 20 weeks or older, unattended by a physician;
- (xiv) 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 months;
- (xv) Deaths occurring outside of a hospital or nursing home, or who are not registered with an official hospice program;
- (xvi) Occupational related deaths attributable entirely or in part to external work place factors;
- (xvii) 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;
- (xviii) Sudden infant death cases, or any unexpected death occurring in infants under the age of 2 years, under circumstances not explained by a preexisting medical problem.

In addition to the above, in order to comply with 1989 Wisconsin Act 336 covering Certified Mental Health and Alcohol Day Treatment Programs, Certified Mental Health Outpatient Programs, Alcohol and other Drug Abuse Detoxification, Inpatient and Outpatient Programs, all deaths in any of these areas that are due to use of restraint and seclusion, psychotropic medications, or suicide, must be reported to the Division of Community Services Regional Area Administration Office, as outlined in the Medical Center Administrative Manual Policy on Reportable Deaths.

## **Section 2. General Conduct of Patient Care.**

- (a) **Medication Use.** All drugs and medications administered to patients shall be those listed in the formulary developed by the Pharmacy & Therapeutics Committee and approved by the Medical Executive Committee. If a physician prescribes a drug that is not on the Medical Center formulary, and the 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 physician prescribes a drug that is not on the formulary, and the Pharmacy & Therapeutics Committee has not made a decision to automatically substitute a formulary agent, a pharmacist will contact the physician to determine if a formulary agent can be substituted for the ordered drug. If the physician feels the ordered drug is necessary, it will be obtained as a non-formulary item for the patient.

Drugs for bona fide clinical investigations that may not be listed in the Medical Center 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 Medical Center's 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 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 physician.

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 Pharmacy & Therapeutics Committee and approved by the Medical Executive Committee. If an unacceptable abbreviation is contained in the physician order the pharmacist shall contact the physician for clarification before carrying out the order in accordance with the AHC System Administrative Policy #147.

- (b) **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 Medical Center 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.
  
- (c) **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 physician writes an order for the patient to continue medications from home, it is the responsibility of that physician to approve the orders for each medication and the dosage regimen.

- (d) **Continued Hospitalization - Attending Physician's Responsibility.** The attending physician 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 hospital, and plans for post-hospital care. This documentation must be in conformance with the criteria and periods of stay specified and approved by the Medical Executive Committee.
- (e) **Frequency of Patient Attendance.** All hospitalized patients will be seen on at least a daily basis by the attending physician, or his or her physician alternate or other designated physician as noted in the medical record, including those patients on a teaching service with the exception of patients on the rehabilitation unit who may be seen every forty-eight (48) hours; **and mental health or partial hospitalization patients who may be seen twice weekly.** The attending practitioner as defined above shall document in the progress notes each patient attendance. This rule may be modified by individual departments with approval by the Medical Executive Committee, as provided for in the Medical Staff Bylaws. 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.
- (f) **Availability of Practitioner and Alternate.** Each practitioner must assure timely, adequate professional care of his or her patients in the hospital by being available and by having available one alternate practitioner who are members of the Medical Staff with at least equivalent clinical privileges at the Medical Center, with whom prior arrangements have been made. An alternate practitioner must be on duty or on call at all times 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 writing on the order sheet on each of his or her patients in the Medical Center. In case of a failure to reach a practitioner and the practitioner's designated alternate, the first available person identified in the hierarchy below will be contacted and shall have authority to obtain the appropriate services needed.

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

- Section Chair

- Service Chief (or Acting Service Chief)
- Physician On Call for this service in the ED
- President of Medical Staff (or Acting President of Medical Staff)
- Administrator

The unavailability of the practitioner and the practitioner's designated alternate will be brought to the attention of the respective Chair or Service Chief by the respective nursing manager. The Section Chair or Department Chief will meet with the practitioner to discuss this matter. Any repeat occurrences will be considered for disciplinary action in accordance with the Medical Staff Bylaws.

(g) **Consultations.** Any qualified practitioner with clinical privileges in the Medical Center may be called for consultation within his or her area of expertise. The attending practitioner or Advanced Practice Professional (APP) 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, the attending practitioner shall consult with another qualified Medical Staff member in the following cases:

1. When the diagnosis is obscure after ordinary diagnostic procedures have been completed
2. When there is doubt as to the choice of therapeutic measures to be used
3. For high risk patients undergoing major operative procedures
4. In situations where specific skills of other physician may be needed;
5. When requested by the patient or his or her family;
6. In other instances as may be defined in departmental rules and regulations; and
7. Where there is question of criminal action.

The practitioner or APP requesting the consultation shall identify in the patient's medical record: (1) the name of the consultant to be contacted; (2) the reason for the consult; and (3) if the consult is either "stat" or "routine." The practitioner or APP requesting the Stat consultation shall be responsible for direct communication with the consultant regarding the requested consultation. Practitioner-to-practitioner communication is strongly recommended on a routine basis. During this communication, the requesting practitioner or APP and the consultant will agree upon a timeframe within which the consultant will evaluate the Stat patient. Nursing will contact the consultant for routine consults. Consults are generally expected to be provided within 24 hours of being requested unless otherwise indicated by patient's condition.

The consultant called in by another practitioner shall be responsible for writing or dictating a report which must show evidence of review of the patient's record by the consultant, pertinent findings on examination, and the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. When operative procedures are involved, the consultant report shall, except in an emergency situation so verified on the record, be recorded prior to the procedure.

In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, the attending practitioner shall either seek the opinion of a second consultant or record in the progress notes his or her reasons for electing not to follow the consultant's advice.

- (h) **Transfer of Patient from one Physician to Another.** If primary responsibility of a patient's care is transferred from one physician to another, the responsibility for the patient's care becomes that of the second physician. This transfer of care shall be recorded in the patient's medical record, on the physician's order sheet, with a signed acceptance by the receiving physician. The original primary physician may not discontinue responsibility for the care of the patient until the receiving physician has acknowledged and accepted the transfer of responsibility.

The attending physician for a patient who becomes medically unstable and requires emergency attention by a member of another service is responsible for identifying a physician from the appropriate service to whose care the patient can be transferred. If the physician to whom the patient is to be transferred refuses to accept the patient, the patient will be assigned to another physician by the Chief of the Department into whose service the patient is being transferred. If the Chief of this Department is not available, the President of the Medical Staff, or in the absence of the President of the Medical Staff, the Vice President of the Medical Staff, will be responsible. This transfer of care shall be recorded in the patient's medical record on the physician order sheet.

- (i) **Critical Lab Values.** To assure that appropriate caregivers are made immediately aware of laboratory test results, which are potentially, or immediately life threatening, a system is in place to notify attending physicians of critical values.
- (j) **Infection Control.** Every practitioner attending patients in the Medical Center shall comply with the policies developed by the Infection Control Committee and approved by the Medical Staff organization, including those that pertain to universal precautions, prevention of communicable diseases, isolation of patients and/or requirements for obtaining cultures for microbiological studies.
- (k) **Code Status.** All patients in the Medical Center must have a code status designated in their medical records. The medical record must indicate the reason for the code status that has been assigned. Determination of patient code status must be made in accordance with the current Medical Center Administrative Manual Policy on Code Status.
- (l) **Restraints and Seclusion.** Use of restraints and/or seclusion must be initiated and continued in accordance with the current Medical Center Administrative Manual Policy on Restraints and Seclusion.
- (m) **Timeliness of Scheduled Services.** All practitioners 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. In no case will the procedure room be held longer than fifteen (15) minutes after the time

scheduled.

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. In no case will a procedure room be held longer than fifteen (15) minutes after the time scheduled.

- (n) **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 Service within which the practitioner has clinical privileges. The Service Chief shall take such action as is deemed warranted by the circumstances.

In the event the Service Chief cannot be reached, the President of the Medical Staff, Vice President, or any other officer of the Medical Staff may be consulted in that order. The Medical Staff officer consulted is responsible for proper examination of the situation. This physician 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. The director of the area shall report, in writing, to the Chief Nursing Executive, with copies prepared to the President of the Medical Staff and the Administrator.

- (o) **Research Protocols.** Research involving use of investigational treatments, procedures, and/or medications must be reviewed and approved by the Medical Center's 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.

### **Section 3. Medical Records.**

- (a) **Components.** Each medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course of treatment and the results accurately, and facilitate continuity of care among health care providers. Each medical record should contain the following:
1. Patient demographics to include name, address, birth date, and authorized representative;
  2. Legal status (for patients receiving mental health services);
  3. Emergency care provided to the patient prior to arrival, if any;
  4. A statement of the conclusions or impressions drawn from the medical history and physical exam;
  5. Diagnosis or diagnostic impression;

6. Reason(s) for admission or treatment;
7. Goals of treatment and treatment plan;
8. Evidence of known advance directives;
9. Evidence of informed consent for any operative and invasive procedures and/or treatment, anesthesia and/or blood products;
10. Diagnostic and therapeutic orders, if any;
11. Results of all ordered diagnostic and therapeutic procedures and tests;
12. All operative and invasive procedure reports;
13. Progress notes;
14. All reassessments, when necessary;
15. Clinical observations;
16. The response to care provided;
17. Consultation reports;
18. Every medication ordered or prescribed for an inpatient, including dosages;
19. Every adverse drug reaction;
20. Every medication dispensed or prescribed for an ambulatory patient or an inpatient at the time of discharge, including dosage;
21. All relevant diagnoses established during the course of care;
22. Any referrals, communications, and patient education provided.

In addition, when emergency care is provided, the medical record shall include documentation of:

- Time/means of arrival;
- Any departure against medical advice;
- Conclusions at the termination of the emergency care is provided to include:
  - a. final disposition;
  - b. patient condition;
  - c. instructions/follow up care.

- (b) **Treatment and Verbal and Telephone Orders.** All orders for treatment shall be entered into the EMR via Computerized Provider Order Entry (CPOE). Verbal orders are only allowable in emergent situations when CPOE would directly endanger patient care. Telephone orders are allowable only when it is unreasonable for the provider to access a computer or not possible for a period of time that is, in the collaborative opinions of the nurse and physician, of such a delay as to possibly impact negatively on patient care.

With the exception of the following, all verbal and telephone orders shall be given to a registered nurse, pharmacist, or resident.

- (i) A respiratory therapist may accept telephone or verbal orders from physicians relative to respiratory and pulmonary services.
- (ii) A licensed physical therapist, occupational therapist, or speech therapist may accept a telephone or verbal order from a physician related respectively to physical therapy, occupational therapy, or speech therapy treatments.



- (iii) A licensed speech therapist may make the judgment to advance or down-grade within a patient's diet order. All other related orders must be given by a physician.
- (iv) An exercise physiologist may accept a telephone or verbal order from a physician related exclusively to exercise therapy.
- (v) A registered dietician may accept a telephone or verbal order from a physician related to nutritional therapy.
- (vi) An infection control coordinator may accept a telephone or verbal order from a member of the Section of Infectious Disease, or any physician member of the Infection Control Committee, relative to implementation of infection control measures.
- (vi) A radiology technician may accept verbal and telephone orders for tests that do not include any type of medications or drugs with the exception of CT of the pelvis.
- (vii) An RN case coordinator may accept a telephone or verbal order from a physician relative to discharge planning and utilization management.

All verbal and telephone orders must be authenticated by the prescribing member of the Medical Staff, or his or her Medical Staff alternate in writing within 48 hours of receipt. Verbal or telephone orders are not considered valid, actionable orders unless they have been read back to the issuing provider and the issuing provider has clearly indicated to the receiving clinician that each order issued is correct. If the issuing provider does not allow appropriate read back and confirmation of each verbal or telephone order, then the nurse will escalate the concern to Medical Staff Leadership.

All verbal or telephone critical test results must be read back to the person reporting the results in accordance with the Metro Administrative and Interdisciplinary Clinical Policy #497 – Critical Test Results Reporting. The person reporting the critical test result will document in the medical record the date, time and three initials of the person receiving and reading back the results.

(c) **Requirements for History and Physical Examinations:**

Individuals That May Perform History and Physical Examinations. Physicians, Doctors of Podiatric Medicine, Nurse Practitioners, Physicians Assistants and Certified Nurse Midwives may perform History and Physical Examinations (H&P) in accordance with the Bylaws, and Policies Governing Medical Practices.

History and Physical Examinations for Inpatients. The Medical Staff Member who is responsible for the care and treatment of a patient during a patient stay is responsible for

ensuring that a H&P is performed, documented and authenticated for each Medical Center inpatient: (a) prior to any non-emergency surgery, (b) any inpatient procedure requiring anesthesia services; or (c) within twenty-four hours of the patient's admission, whichever occurs first. If a complete medical history and physical examination has not been performed within thirty (30) days prior to inpatient admission, a complete medical history and physical examination shall be performed and recorded in the medical record within twenty-four (24) hours of an inpatient admission. If a complete medical history has been performed and recorded by a Medical Staff Member within thirty (30) days of an inpatient admission, a full medical history and physical need not be performed upon admission; provided, however, that an update to such medical history and physical is performed and recorded in the patient's medical record within twenty-four (24) hours of the inpatient admission noting any changes in the patient's condition. An updated medical history and physical examination must be completed prior to an operative or invasive procedure requiring anesthesia services.

History and Physical Examination for Ambulatory/Outpatients. If a Medical Center outpatient will undergo a surgical or other procedure requiring anesthesia services (other than local anesthesia) the Medical Staff Member 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.

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 judgement. However, the following criteria should apply:

- (i) 37 or greater weeks gestational age.
- (ii) May have been delivered via cesarean section or vaginally with or without instrumentation.
- (iii) Normal vital signs on day of discharge.
- (iv) Normal glucose homeostasis.
- (v) Normal pulse oximetry screening (if done).
- (vi) Normal feeding, stooling and voiding patterns.
- (vii) Appropriate screening and management of jaundice.
- (viii) Appropriate parent/guardian disposition and follow up physician identified.

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 status. A complete H&P shall be performed and recorded as soon as possible, and within 24 hours of the decision to admit the patient as an inpatient.

Pre-Admission H&Ps and Updates. An H&P performed by a qualified physician or allied health professional 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 current Medical Staff or an APP with Clinical Privileges at the Medical Center); however, when a pre-admission/registration H&P is used, a Medical Staff Member or APP with Clinical Privileges 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 Medical Staff Member or APP with Clinical Privileges 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 Medical Staff Member or APP with Clinical Privileges 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.

Psychiatric Evaluation. The Medical Staff Member who is responsible for the care and treatment of a patient admitted to psychiatric or substance abuse treatment will have a comprehensive mental health or addiction assessment performed, documented and authenticated within: (1) twenty-four (24) hours for inpatient and direct admission residential care, (2) sixty (60) hours for partial hospital care.

If a comprehensive mental health or addiction assessment has been performed and recorded by a Medical Staff Member within thirty (30) days of an inpatient, residential or partial hospital admission, a comprehensive assessment need not be performed upon admission; provided, however, that an update to such comprehensive mental health or addiction assessment has been performed and recorded in the patient's medical record noting the new chief complaint, reason for admission, current mental status and any other changes in the patient's condition within: (1) twenty-four (24) hours for inpatient and direct admission residential care, (2) sixty (60) hours for partial hospital care.

**Required Elements of History and Physical Examination Documentation:**

- (i) **Basic Inpatient History and Physical** (for patients who are not scheduled for an operative or invasive procedure):

The H&P shall include:

- Reason for admission;
- Physical assessment (review of systems, including comorbid conditions);
- Mental status;
- Medical history, including past response to treatment, known allergies, current medications and dosages, relevant social and family history appropriate to the age of the patient;
- Diagnostic impression;
- Treatment plan and goals.

(ii) **History and Physical prior to Inpatient Operative or Invasive Procedure and/or Anesthesia/Conscious Sedation:**

The H&P shall include:

- All requirements listed in (i) above;
- Indications for the procedure;
- Evaluation of the operative site;
- Examination of the heart and lungs by auscultation;
- Airway assessment;
- ASA classification;
- Sedation plan;
- Reassessment immediately prior to sedation. This typically should not be in the H&P but rather on the operative record or conscious sedation record.

(iii) **Ambulatory/Outpatients with Operative or Invasive Procedures and/or Anesthesia/Conscious Sedation.**

The H&P shall include:

- Indications for the procedure;

- Current medications and dosages;
- Known allergies, including medication reactions;
- Existing comorbid conditions;
- Evaluation of the operative site;
- Examination of the heart and lungs by auscultation;
- Airway assessment;
- ASA classification;
- Sedation plan;
- Reassessment immediately prior to sedation. This typically should not be in the H&P but rather on the operative record or conscious sedation record.

(iv) **Ambulatory/Outpatients with Operative or Invasive Procedures and Local Anesthesia or Peripheral Nerve Block.**

The H&P shall include:

- Indications for the procedure;
- Mental status;
- Examination specific to the procedure being performed;
- Comorbid conditions.

(v) **Section of Dentistry/Dental/Oral Maxillofacial Surgery.** When patients are admitted to the Medical Center for dental services or dental/oral maxillofacial surgery, a medical survey of the patient must be done and recorded by the responsible physician before dental/oral maxillofacial surgery is performed. A detailed dental history must be recorded justifying the hospital admission. In addition, a detailed description of the examination of the oral, maxillofacial structures and a preoperative diagnosis must be recorded.

Oral maxillofacial surgeons who are Medical Staff Appointees and have been specifically granted history and physical privileges may perform a complete admission history and physical examination to assess the medical risk of their patients' oral, maxillofacial procedures.

(d) **Preoperative Diagnosis.** A preoperative diagnosis must be recorded before surgery by the licensed independent practitioner responsible for the patient.

(e) **Operative Reports.** The performing provider must either:

- enter or dictate a complete operative 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
- enter a progress note immediately after the procedure (the “brief op note”) and dictate or write a full operative report within twenty four (24) hours of the procedure (note that if the complete operative report is entered directly into Epic, then no “brief op note” need be entered but if the complete operative report is dictated into the transcription system then a “brief op note” must be completed immediately after the procedure and before the patient is transferred to the next level of care); or
- accompany the patient from the procedure room to the next unit or area of care, and enter or dictate a full operative report (following the guidelines above) in the new unit or area of care.

All complete operative reports must be authenticated within 4 calendar days of the procedure’s completion, unless the performing provider goes on verified vacation or leave before the dictation is available to be signed, in which case the procedure dictation must be authenticated within 24 hours of verified return to work.

Complete Operative reports shall include:

- Date and time of the procedure
- Pre-procedure diagnosis
- Type of anesthesia administered
- Name/description of the procedure performed
- Name of the primary surgeon and the name of any individual (e.g. surgical assistant) who performed a significant surgical or procedural task during the operation (even when performing those tasks under supervision)
- Estimated blood loss
- A detailed account of the findings
- Complication(s), if any
- Details of the surgical technique used
- Specimens removed, if any
- Post-operative diagnosis

Specimens removed during an operative procedure shall be handled according to the Medical Center Administrative Manual Policy, "Specimens Removed During an Invasive or Surgical Procedure."

- (f) **Progress Notes and Frequency.** Pertinent progress notes shall be recorded at the time of observation and shall be sufficient to permit continuity of care and transferability. Progress notes shall be recorded at least daily on all patients.
- (g) **Clinical Entries.** All clinical entries in the patient's medical record shall include the date, time, and signature, to reflect the actual date, time and author at the time of writing. All entries shall be authenticated by a written signature, identifiable initials, or computer key. Entries in the patient's medical record shall be made only by those professionals with pertinent knowledge of the assessment, care and treatment, or other needs of the patient and his or her family. This includes the credentialed Medical Staff Appointees involved in the cases and their employed staff who have been appointed members of the Allied Health Professional Staff of the Medical Center, residents and fellows approved through the Medical Education Department of the Medical Center, employees of the Medical Center as defined in the policies and procedures of their department, students enrolled in an approved training program as allowed by the Medical Center, contracted staff as defined by contract or policy and procedures, and pre-hospital care givers such as paramedics and emergency medical technicians.
- (h) **Consultation Reports.** Consultation reports shall show evidence of a review of the patient's record, examination of the patient, the consultant's opinion, and the consultant's recommendations. Consultation reports shall be authenticated by the consulting practitioner.
- (i) **Discharge Summaries.** A discharge summary shall be recorded and authenticated in the medical records of all patients within 3 calendar days of discharge.

The discharge summary shall concisely summarize the following:

- Reason for admission/admitting diagnosis;
  - Physical examination;
  - Diagnostic studies performed during hospitalization;
  - Significant findings;
  - Operative and other invasive procedures performed;
  - Treatment rendered;
  - Consultations;
  - Condition of the patient at discharge;
  - Any specific instructions to the patient or family or both the patient and family, including those regarding diet, medications, physical activity, and follow-up care;
  - Final diagnosis and discharge disposition.
- (j) **Use of Rubber Stamp.** The use of a rubber signature stamps is prohibited.

- (k) **Symbols and Abbreviations.** Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of the approved symbols and abbreviations shall be kept on file in the Medical Record Department, the pharmacy, nursing units, and other appropriate areas within the Medical Center. There is also a listing of unacceptable abbreviations that cannot be used in accordance with the AHC System Administrative Policy #147. If an unacceptable abbreviation is contained in the physician order/note, the caregiver shall contact the physician for clarification before carrying out the order.
- (l) **Completeness, Legibility, and Pertinence of Medical Records.** The attending practitioner shall be responsible for the preparation of a complete, legible medical record for each of his or her patients. The contents of the record shall be pertinent and current. The record shall include such data, information, notes and reports as will conform with criteria established within policies and procedures of individual departments and/or the committee charged with the medical record review function. No clinical record may be considered complete until so certified by the signature of the attending practitioner.
- (m) **Timeframe for Record Completion and Sanctions for Delinquency.**

Policy:

- (i) Any Medical Staff member who has any delinquent records will have his or her privileges suspended. A record is considered delinquent fifteen (15) days after the patient's inpatient or outpatient visit or the deficiency has been allocated, whichever ever comes first and is applied toward all medical record types – H&P's, operative reports, discharge summaries, procedure notes (inpatient and outpatient) and outpatient progress notes/hospital-based clinical visits of any kind. Deficiencies may include missing documentation, missing signatures on orders and/or missing signatures on entries. This means:

Medical Staff members will not be allowed to admit elective inpatients or outpatients.

Medical Staff members will not be allowed to advance schedule inpatient or outpatient procedures.

Since procedures currently advance scheduled will not be cancelled, Medical Staff members are expected to have their suspension removed prior to the date of admission/procedure.

- (ii) Emergency admissions through the Emergency Department are not affected, therefore, Emergency Department call is not affected. An increase in emergency admissions from Medical Staff members with suspended privileges will be reviewed by the member's Department Chief.



- (iii) The attending physician, not resident, has the responsibility for the documentation of medical care. Failure of a resident to complete the record during the fifteen (15) day period does not absolve the attending from suspension, although it is the requirement of the Medical Education programs that residents and fellows schedule medical records completion weekly. It is anticipated that the attending Medical Staff member will include accountability for completion of the medical record as a part of resident training.
- (iv) In determining the appropriateness of suspension, the Medical Records Department will factor in circumstances beyond the Medical Staff member's control. These include: prior notification of vacations or other absences and the unavailability of a medical record.
- (v) To be removed from suspension the Medical Staff member must complete all available delinquent deficiencies from the in-basket.
- (vi) Once the Medical Staff member has completed his or her records, the Medical Records Department will be notified automatically, the following day, via SmartChart Report. Any physician needing scheduling privileges reinstated more quickly should contact their respective Medical Record Department. The Medical Record Department will verify delinquencies are complete and will remove the physician from the suspension status and will notify the appropriate departments.
- (vii) Medical Staff members on suspension may consult as requested on inpatients.
- (viii) Medical Staff members on suspension for Medical Records will be allowed to refer patients to the Medical Center for diagnostic testing that does not require that the Medical Staff member be in attendance.
- (ix) Medical Staff members whom are on suspension for more than fifteen (15) days OR have three (3) episodes of suspension in a twelve (12) month period will result in an automatic voluntary relinquishment of Medical Staff privileges. The fifteen (15) days will commence on the day the Medical Staff member is notified.
- (x) Any requests for exceptions to this policy and procedure shall be directed by the Medical Staff member to the Administrator.
- (n) **Permanent Filing of Records.** Medical records shall not be permanently filed until completed by the practitioner or ordered filed by the Medical Staff Leadership Council of the Medical Center.
- (o) **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 release of information staff in the Medical Records Department.

- (p) **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.
- (q) **Readmission, Access to Previous Records.** In case of a readmission of a patient, all previous medical records shall be available for the use of the current attending practitioner whether the patient was attended by the same practitioner or by another.
- (r) **Access to Records for Clinical Investigation/Research.** Access to all pertinent medical records of patients shall be made available to members of the Medical Staff in good standing for bona fide clinical investigations and research, subject to state and federal regulations regarding confidentiality, and in a manner that preserves the confidentiality of personal information concerning the individual patient, provided that such clinical investigations or research have been approved by the Institutional Review Board when appropriate.
- (s) **Patient Confidentiality.** It is the policy of the Hospital and the Medical staff to maintain medical records in a manner that preserves confidentiality of patient health information.

All Medical Staff members and Medical Affiliates agree to comply with the Hospital's 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 of the Hospital 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 ("Notice"). 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 physician 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.

#### **Section 4. Operative and Invasive Procedures.**

- (a) **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.

- (b) **Surgery** means treatment of human beings by a practitioner, by the use of one or more of dislocations of a bone, joint, or bony structure; repair of malformations or body defects resulting from injury birth defects, or other causes that require cutting and manipulation or suture; instrumentation of the uterine cavity including the procedure commonly known as a D&C for diagnostic or therapeutic purposes; any instrumentation of or injection of any substance into the uterinecavity of a woman for the purpose of terminating a pregnancy; human sterilization procedures or endoscopic procedures.
- (c) **Informed Consent** means a written consent form that contains the required information. A signed Consent Form is required for the following inpatient or outpatient treatments:
- (1) Any treatment that requires conscious sedation or general anesthesia; and/or
  - (2) Any treatment that involves the insertion of a needle, instrument, or other device into the body by needle puncture, incision or through a body orifice, and presents more than minimal risk to the patient (or to a fetus, if the patient may be, or is known to be pregnant).
  - (3) Any surgery as defined above.

**SPECIFIC TREATMENTS/PROCEDURES THAT REQUIRE A SIGNED CONSENT FORM:**

- All Surgical Department / Operating Room procedures
- All Cardiac Catheterization Lab / Electrophysiology Lab procedures
- All elective cosmetic treatments
- Any treatment involving conscious sedation or general anesthesia
- Any treatment involving the implantation or transplantation of a device, tissue, or tissue product
- Radiation Therapy
- Medical Imaging – See Radiology/Imaging Services policy on Informed Consent
- Aspiration/drainage: chest tube, thoracentesis, paracentesis, spinal tap, deep tissue aspiration, bone marrow aspiration
- Biopsy: organ biopsy, breast biopsy, deep tissue biopsy
- Vascular access / in-dwelling catheter placement: pheresis catheter, line, or port placement, including: central line, Permacath, Mahurkar, Hickman, Groshong; temporary pacemaker, PICC lines. PICC line consent may be obtained by performing practitioners who have been credentialed or otherwise granted the permission to insert PICC lines.
- Injection of medications: injections into the epidural space or spinal column, Botox and cosmetic fillers, chemotherapy, nerve blocks, or cisternogram. If the medication is continuous or a series, consent need only be obtained at the start of the medication process.
- Miscellaneous: certain treatments have unique informed consent requirements, see hospital policies for more information on specific consent requirements for any of these topic areas:
  - Blood/Blood Products
  - Organ/Tissue Donation and Transplantation
  - Reproductive Services (Birth Control, Abortion, Insemination, etc.)
  - Transfer of Patient with Emergency Medical Condition (EMTALA)

Compliance)

- Mental Health, Developmental Disability, and AODA Services
- Treatment Requested/Directed by Law Enforcement
- Testing for Alcohol / Controlled Substances
- HIV Testing
- Electroconvulsive Therapy (ECT)
- DNR Orders / State DNR Bracelets
- Research
- Autopsy
- SANE Examinations / Evidence Collection
- Photography/Observation
- Withholding and Withdrawal of Treatment

- (d) **Time-Out.** In accordance with the Administrative Policy #149 Universal Protocol for Prevention, 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.

#### **Section 5. General Medical Staff Matters.**

- (a) **Medical Staff Dues.** Medical Staff dues shall be set by the Metro Medical Executive Committee as outlined in the Medical Staff Bylaws.
- (b) **Emergency Preparedness Responsibilities.** Each member of the active Medical Staff 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 physician 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 physician 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 hospital to another or from the hospital premises entirely.

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

- (c) **On Call Response Time.** In order to assure timely medical care to patients presenting in the Emergency Department, physicians providing on-call backup must respond within twenty (20) minutes of being contacted by the Emergency Department. If the physician on call is requested by the Emergency Room to treat an unstable patient, the on-call physician shall report to the hospital within a mutually agreed upon time period of being requested to do so.
- (d) **Failure to respond.** Physicians who fail to accept or fulfill their obligations for ER back-up call shall be subject to corrective action.
- (e) **Personnel Authorized to Perform Medical Screening Examinations.** Physician members of the Medical Staff and advanced practice professionals (that is, nurse practitioners and physician assistants) 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.

A registered nurse who has established competencies in psychiatric assessment 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.

For sexual assault victim patients, the medical screening exam may be performed by either a member of the medical staff, or an advanced practice professional, or a trained sexual assault nurse examiner (SANE) nurse from the Sexual Assault Treatment Center.

If an advanced practice professional or SANE performed the initial medical screen examination, a physician member of the Medical Staff will further evaluate these sexual assault victim patient's with any of the following conditions:

- (1) History of head trauma that includes loss of consciousness, lack of orientation, or vision/hearing changes
- (2) Evidence of substance use or abuse that would render the victim incapable of giving informed consent to or cooperating with the sexual assault examination
- (3) Chest or abdominal pain
- (4) Twisting injury to extremities that results in limited range of motion
- (5) History or evidence that foreign objects have been inserted rectally, vaginally or orally
- (6) History or evidence of unexplained vaginal bleeding since assault
- (7) Pregnancy with complications or imminent delivery
- (8) Evidence of vaginal, labial, or perineal bruising or laceration requiring treatment
- (9) Patient report or current suicidal or homicidal ideation

- (10) Patient report of strangulation

**Section 6. Other Provisions.**

(a) **Confirmation of Immunities, Releases and Confidentiality.**

- (1) By applying for appointment and/or clinical privileges as part of the Medical Staff of this Medical Center, each Applicant or Medical Staff Appointee shall agree to exercise his or her appointment and clinical privileges within the Medical Center subject to the provisions contained within these Policies Governing Medical Practices, along with the Medical Staff Bylaws, and any other written policies, procedures or directives of the Medical Executive Committee or Governing Board, including any restrictions or limitations attached to his or her appointment or clinical privileges and those sections of these Policies Governing Medical Practices, the Medical Staff Bylaws, or Medical Center policies and procedures regarding immunities, releases from liability, and confidentiality.
- (2) Any Medical Staff officer, Department Chief, committee chairman, committee member or individual Medical Staff Appointee who acts for and on behalf of the Medical Center in discharging professional duties, functions or responsibilities stated in these Policies Governing Medical Practices, the Medical Staff Bylaws, and the Medical Staff Bylaws Provisions Related to the Appointment, Re-appointment, Clinical Privileges and Corrective Action Policies and the Fair Hearing Plan, (Uniform Policies) and/or other relevant Medical Center policies and procedures impacting on the Medical Staff, shall be indemnified to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Governing Board.
- (b) **Construction.** These Medical Staff Policies Governing Medical Practices, along with the Medical Staff Bylaws, including the Fair Hearing Plan, shall serve as the guidelines for the operations and discipline of the Medical Staff together with such policies and procedures as may be necessary to further implement the general principles found within these Policies Governing Medical Practices, in order to promote the delivery of quality health care within the Medical Center and to provide for the efficient operation of the Medical Center. These Policies Governing Medical Practices shall be implemented and interpreted so as to meet all requirements for protection under the Act, including the adequate notice and hearing requirements of § 11112 (a) (3) of the Act. In no case shall these Policies Governing Medical Practices exceed in scope or contradict in meaning or extent the Medical Staff Bylaws.
- (c) **Distribution.** A copy of these Medical Staff Policies Governing Medical Practices shall be made available to all Medical Staff Appointees at the time of their adoption. Proposed revisions shall be made available to all Medical Staff members in advance of approval by the Medical Executive Committee and the Governing Board, in accordance with the Medical Staff Bylaws. A copy of these Medical Staff Policies Governing Medical Practices, as amended and in effect, shall also be made available to each medical staff member who requests an application for appointment to the Medical Staff. Copies of these Medical Staff Policies Governing Medical Practices and all amendments hereto

shall be maintained in the Medical Staff Office of the Medical Center.

(d) **Adoption.**

- (1) These Medical Staff Policies Governing Medical Practices shall be subject to adoption and approval by the Medical Executive Committee of the Metro Medical Staff, and shall be adopted and approved by the Governing Board of Aurora Health Care Metro, Inc.

**Adopted:** January 9, 1990

**Revised:** 2-21-91; 7-24-96; 8-27-97; 11-01; 1-20-02; 6-17-02; 10-20-02; 1-20-03; 12-01-03; 1-19-04; 7-19-04; 9-20-04; 11-29-04; 2-10-05; 5-05-05; 8-22-05; 9-17-05; 8-18-06; 1-23-07; 4-25-07; 12-17-08; 3-1-11; 10-4-12; 06-06-13; 04-21-14, 10-20-14, 05-18-15; 8-15-16; 9-19-16; 1-16-17; 10-16-2017