# TABLE OF CONTENTS

1. ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS ........................................ 1  
   1.1 Admitting Privileges .................................................................................. 1  
   1.2 Definitions of Patient Populations by Age .............................................. 1  
   1.3 Order of Priorities for Admissions ............................................................ 1  
   1.4 Observational Care Admission ................................................................. 1  
   1.5 Admitting Practitioner Responsibilities ................................................... 2  
   1.6 Admitting Orders ...................................................................................... 2  
   1.7 Psychiatric Admissions ............................................................................ 2  
   1.8 Admissions to Intensive Care ................................................................. 3  
   1.9 Admission Examination and Tests ............................................................ 3  
   1.10 Admission Agreement and Consent for Treatment ................................. 3  
   1.11 Who Can Write Orders ........................................................................... 3  
   1.12 Patient Transfer .................................................................................... 6  
   1.13 Patient Discharge .................................................................................. 6  
   1.14 Patient Death ......................................................................................... 7  
   1.15 Organ Donation ..................................................................................... 7  
   1.16 Autopsy .................................................................................................. 7  
   1.17 Reportable Deaths ................................................................................. 9  

2. GENERAL CONDUCT OF PATIENT CARE  
   2.1 Medication Use ......................................................................................... 10  
   2.2 Sample Medications ................................................................................ 11  
   2.3 Patient’s Medications from Home ............................................................ 11  
   2.4 Continued Hospitalization – Attending Practitioner’s Responsibility .... 11  
   2.5 Frequency of Patient Attendance ........................................................... 11  
   2.6 Availability of Practitioner or Alternate ................................................ 12  
   2.7 Consultations ......................................................................................... 12  
   2.8 Critical Lab Values .................................................................................. 13  
   2.9 Infection Control ..................................................................................... 13  
   2.10 Code Status .......................................................................................... 13  
   2.11 Timeliness of Scheduled Services ....................................................... 13  
   2.12 Mechanism for Handling Concerns about Patient Care ....................... 14  
   2.13 Research protocols ............................................................................. 14  

3. MEDICAL RECORDS  
   3.1 Components ........................................................................................... 14  
   3.2 Treatment Orders Including Verbal Orders .......................................... 15  
   3.3 Completeness/Timeframe for Completion ............................................. 15  
   3.4 Excessive Medical Record Deficiency ................................................... 15
Informed Consent or Refusal ................................................................. 15
3.6 Treatment and Verbal and Telephone Orders .................................. 15
3.7 Requirements for History and Physical Examinations .................. 16
3.8 Pre-Procedural Documentation ....................................................... 19
3.9 Procedure (Operative) Report ....................................................... 19
3.10 Anesthesia Evaluations and Reports ............................................ 20
3.11 Discharge Summary ................................................................. 21
3.12 Ongoing Ambulatory Care .......................................................... 22
3.13 Anatomical Gifts ................................................................. 22
3.14 Restraints and Seclusion ............................................................ 22
3.15 Adverse Events ................................................................. 22
3.16 Closure of Incomplete Medical Records .................................... 22
3.17 Release of Medical Records ....................................................... 22
3.18 Removal of Records from the Medical Center ......................... 22
3.19 Readmission, Access to Previous Records ................................. 23
3.20 Access to Records for Clinical Investigation/Research ................ 23
3.21 Patient Confidentiality ............................................................. 23

4. OPERATIVE AND INVASIVE PROCEDURES
4.1 Anesthesia ................................................................. 23
4.2 Surgery ................................................................. 23
4.3 Surgical Site Marking ............................................................. 23
4.4 Time-Out ................................................................. 24
4.5 Specimens ................................................................. 24

5. GENERAL MEDICAL STAFF MATTERS
5.1 Emergency Preparedness Responsibilities .................................. 24
5.2 On Call Response Time .......................................................... 24
5.3 Failure to Respond ............................................................. 24
5.4 Personnel Authorized to Perform Medical Screening .................. 25
5.5 Disclosure ................................................................. 25
5.6 Medical Staff Conduct .......................................................... 25

6. OTHER PROVISIONS
6.1 Confirmation of immunities, Releases and Confidentiality .......... 25
6.2 Construction ................................................................. 26
6.3 Distribution ................................................................. 26
6.4 Adoption ................................................................. 26
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 Unified Medical Staff Bylaws ("Practitioner"). Aurora Medical Center Washington County utilizes Advanced Practice Clinicians (APC) as part of an Adult Inpatient Medical Service. APCs do not have admitting privileges, but may perform other Practitioner functions, as outlined in this document, per Wisconsin State statutes.

1.2 **Definitions of Patient Populations by Age.**

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

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

1.3.1 **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.

1.3.2 **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.

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

1.3.4 **Routine Admission.** Elective admission involving all services.

1.4 **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 Site Leadership Council.
1.5 **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.

1.6 **Admitting Orders.** The attending Practitioner or his or her designated alternate must provide admitting orders to the nursing unit 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 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 Chief (if one has been appointed)
- Department Chair
- Chief of Staff of the Medical Staff
- Chief of Staff Elect of the Medical Staff

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

Failure of a Practitioner to be available for the care of hospitalized patients shall be referred to the Practice Evaluation Committee.

1.7 **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 Advocate Aurora Heath Care System Policies.
1.8 **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 standard medical practice based on the admitting practitioner’s assessment of the patient’s medical condition.

The admitting Practitioner or his/her designated consultant should see a patient within a timely fashion of admission to an intensive care unit. This is generally expected to be within two (2) hours or sooner if the decision to admit to intensive care as warranted by the patient’s condition.

1.9 **Admission Examination and Tests.** A routine examination will be made of all patients in a timely fashion. This is generally expected to be within six (6) hours of admission unless admitted to Intensive Care as per Section 1.5. Appropriate admission tests, as determined by the admitting Practitioner or APC, shall be performed on each patient admitted to the Medical Center. A preoperative diagnosis will be recorded prior to surgery.

1.10 **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 System policies for consents.

1.11 **Who can Write Orders.** In addition to members of the Medical Staff, the following practitioners can issue orders if authorized by the Site Leadership Council 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
- registered dieticians (limited to therapeutic diet orders)
- a licensed speech therapist (limited to the advancement or downgrading within a patient’s diet order)

In accordance with the Advocate Aurora Health Care System Policies, the ordering or performing Practitioner or ordering or performing APC 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.
1.12  Patient Transfer.

1.12.1  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. 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.

1.12.2  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 Chief or Department Chair of the Department into which the patient is being transferred. If the Section Chief or Department Chair is not available, the Chief of Staff of the Medical Staff, or in the absence of the Chief of Staff, the Chief of Staff 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.

1.12.3  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 order of the attending Practitioner in accordance with the procedures set forth in Section 1.9 (Patient Discharge). The attending Practitioner or APC 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 the Policy Governing Medical Practices). The attending Practitioner or APC 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. All APCs who are part of the Adult Inpatient Medicine Service are considered Qualified Medical Persons and are able to sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer.

1.13  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 Advocate Aurora Health Care System policies. 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.

1.13.1 **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 as defined by Advocate Aurora Health Care policies.

1.13.2 **Objections to Discharge.** If a patient objects to discharge from the Medical Center, contact Case Management. The medical staff member will discuss options with hospital Case Management. Options will be provided to the patient. If the patient remains at the medical center, the attending physicians will remain responsible for the care of the patient.

1.13.3 **Discharge Against Medical Advice.** 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.

1.14 **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.

1.15 **Organ Donation.** Every member of the Medical Staff is expected to comply with the Advocate Aurora Health Care policies 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.

1.16 **Autopsy.** It shall be the responsibility of all Practitioners and APCs to secure written permission for meaningful autopsies whenever possible. If an individual
other than the attending Practitioner requests an autopsy, the individual who makes the request must notify the attending Practitioner of the request. Autopsies shall be obtained in accordance with the Advocate Aurora Health Care System Policies, current State regulations as set forth in DHS 135.04(2), and the guidelines established by the Washington 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.
1.16.1 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.

1.17 Reportable Deaths. It is the initial responsibility of the attending physician or designated alternate to report to the Washington County Medical Examiner’s Office deaths which occur in the hospital, that occur under any of the circumstances listed below, as outlined in the Advocate Aurora Health Care System policies. 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.

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

2.1 **Medication Use.** Drugs and medications administered to patients shall be those listed in the formulary developed by the Aurora Health Care Pharmacy & Therapeutics Committee and enforced by the Site Leadership Council. In compliance with Advocate Aurora Health Care System Policies, non-formulary medications may be considered for patient-specific circumstances in which the use of the agent is clinical necessary.

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).

2.1.1 **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 physician.

2.1.2 For outpatient/ambulatory 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 and APC 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 order as described in the Advocate Aurora Health Care System Policies, the pharmacist shall contact the prescriber for clarification before carrying out the order.

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 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.

2.3 Patient’s Medications from Home. Patient use of medications brought from home is prohibited unless specifically ordered by the attending Practitioner or APC. 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 prescriber writes an order for the patient to continue medications from home, it is the responsibility of that prescriber 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 clinician 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 attending Practitioner or APC shall document in the progress notes each patient attendance. This rule may be modified by individual departments with approval by the Site Leadership Council, as
provided for in the Unified 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.

If a progress note is entered by an advanced practice clinician, applicable Practitioner co-signature requirements as outlined in the “Hospital Co-Signature Requirements” located on the Aurora Health Care Compliance and Integrity AHC website must be met.

2.6 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 the patient’s medical record 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:

- Department Chair
- Chief of Staff
- Chief of Staff Elect

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

2.7 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 Clinician (APC) 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:

2.7.1 When the diagnosis is obscure after ordinary diagnostic procedures have been completed
2.7.2 When there is doubt as to the choice of therapeutic measures to be used
2.7.3 For high risk patients undergoing major operative procedures
2.7.4 In situations where specific skills of other physician may be needed;

2.7.5 When requested by the patient or his or her family;

2.7.6 In other instances as may be defined in departmental rules and regulations; and

2.7.7 Where there is question of criminal action.

The Practitioner or APC 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 APC 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 APC 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.

2.8 Critical Lab Values. To assure that appropriate caregivers are made immediately aware of critical test results, which are potentially, or immediately life threatening, a system is in place to notify attending physicians of critical values.

2.9 Infection Control. Every Staff Member 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 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.
2.12 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 Department Chair within which the practitioner has Clinical Privileges. The Department Chair shall take such action as is deemed warranted by the circumstances.

In the event the Department Chair cannot be reached, the Chief of Staff or Chief of Staff Elect 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.

2.13 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 be maintained as set forth in the Advocate Aurora Health Care System Policies and the Unified Medical Staff Bylaws.

3.2 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 orders within forty-eight (48) hours. The following Practitioners may independently issue treatment orders if granted the privileges to do so:

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

Verbal orders should be reserved for urgent and emergent situations. Face-to-face verbal orders are not acceptable except in the case of an emergent situation. All verbal orders must be read back to the Practitioner giving the order to verify accuracy. It is expected that a Practitioner’s verbal order usage will be kept to a minimum.

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

3.3 Completeness/Timeframe for Completion. All entries in the medical record must be complete. A medical record entry 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 and billed; (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 thirty (30) days of the patient’s discharge.

3.4 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 Unified Medical Staff Bylaws.

3.5 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.

3.6 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.

3.6.1 A respiratory therapist may accept telephone or verbal orders from physicians relative to respiratory and pulmonary services.

3.6.2 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.
3.6.3 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.

3.6.4 An exercise physiologist may accept a telephone or verbal order from a physician related exclusively to exercise therapy.

3.6.5 A registered dietician may accept a telephone or verbal order from a physician related to nutritional therapy.

3.6.6 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.

3.6.7 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.

3.6.8 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, actable 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.

3.7 Requirements for History and Physical Examinations:

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

3.7.2 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.

3.7.3 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.

3.7.4 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.

3.7.5 Pre-Admission H&Ps and Updates. An H&P performed by a qualified physician or advanced practice clinician 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 APC with Clinical Privileges at the Medical Center); however, when a pre-admission/registration H&P is used, a Medical Staff Member or APC 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 APC 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 APC 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.

**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/Procedural 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;
- The following should be included if not documented elsewhere in the medical record:
  - 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 pre-sedation record.

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

The H&P shall include:
- Indications for the procedure;
- Current medications and dosages;
- Known allergies, including medication reactions;
- Existing comorbid conditions or problem list;
- Medical history;
- Relevant family and social history;
- Relevant review of systems
- Mental status
- Physical exam including auscultation of heart and lungs;
  - The following should be included if not documented elsewhere in the medical record: Airway assessment;
  - ASA classification;
  - Sedation plan;
- Reassessment immediately prior to sedation. This should not
be in the H&P but rather on the operative record or pre-sedation record.

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

The Pre-Local Assessment 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.

3.8 **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 sedation or anesthesia (e.g., any procedure requiring written informed consent).

- **Pre-Sedation Assessment and History and Physical exam with interval update if indicated,** shall be present on the medical record prior to any administration of procedural or anesthesia. Except of Local Anesthesia cases which a Pre-local Assessment is completed (no History and Physical exam required).
- Patient’s written informed consent
- Consultation reports as relevant
- Results of all relevant laboratory, EKG and x-ray studies per the AAH Pre-Anesthesia Evaluation Guidelines.

3.9 **Procedure (Operative) Report.** An operative or other high-risk procedure report is done upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital. Note 2: If the practitioner performing the operation or
high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

A full procedure report must be entered for all procedures no more than twenty-four (24) hours following procedure.

A brief procedure report must be signed by the performing Practitioner and must include the following information:

- Date and time of the procedure;
- Pre-procedure diagnosis;
- 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 procedures/findings/post operative diagnosis / complications;
- As applicable: estimated blood loss, specimens removed;
- Post-procedure evaluation, and;
- Practitioner plan 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;
- Practitioner plan of care.

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

3.10.1 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.

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

3.10.3 Intra-operative Report. The anesthesia practitioner shall complete an intraoperative report, which shall include at minimum: (a) the name and profession of the Practitioner who administered the anesthesia, the supervising anesthesiologist (if applicable) and the performing surgeon/proceduralist, (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.

3.10.4 Post-Procedure Evaluation. No later than forty-eight (48) hours after a procedure resulting in an admission, a post-anesthetic follow-up examination must be completed and documented in the medical record by a Practitioner who is authorized to administer anesthesia.

3.11 Discharge Summary. The attending Practitioner or APC is responsible for ensuring that a Discharge Summary is entered or dictated within fourteen (14) days after discharge. Discharge Summaries by APC’s must be co-signed by the attending/admitting Practitioner within thirty (30) days of the patient’s discharge. If the Discharge Summary is entered or dictated more than twenty-four (24) hours prior to the patient’s actual discharge, the discharging Practitioner or APC must ensure the Discharge Summary is updated. 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.

3.12 Ongoing Ambulatory Care. For each patient who receives ongoing ambulatory care services, the medical record must contain a summary list that includes the following: (a) any significant medical diagnosis and conditions; (b) any significant operative and invasive procedures; (c) any adverse or allergic drug reactions; and (d) any current medications and herbal preparations. The summary list is updated whenever a procedure is performed.

3.13 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.

3.14 Restraints and Seclusion. The medical record must contain required documentation regarding the use of restraints or seclusion, as specified in the Advocate Aurora Health Care System Policies.

3.15 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.).

3.16 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 administratively closed on the authority of the Site Leadership Council.

3.17 Release of Medical Records. Any and all requests for copies of medical records should be directed to the Medical Records Department. Records will be released in compliance with Advocate Aurora Health Care System Policies.

3.18 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.
3.19 **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.

3.20 **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.

3.21 **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 Heath Information will subject the Practitioner to corrective action as outlined in the Unified 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 expectation that, in the manner used, the sedation or analgesia will result in the loss of protective reflexes. Sedation will be provided in full compliance with the System Policies.

4.2 **Surgery** means treatment of human beings by a practitioner, by the use of one or more of the following procedures: cutting into any part of the body by surgical scalpel, electro-cautery, or some other means for diagnosis or removal of foreign bodies; reduction of fractures or 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 uterine cavity of a woman for the purpose of terminating a pregnancy; human sterilization procedures or endoscopic procedures.
4.3 **Surgical Site Marking.** Marking of the surgical site shall be performed in accordance with Advocate Aurora Health Care policies.

4.4 **Time-Out.** In accordance with the Advocate Aurora Health Care System Policies 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.

4.5 **Specimens.** Specimens removed during an operative or invasive procedure shall be handled in accordance with ACL Policy Manual, “Specimen Collection in Surgical Areas”.

5 **GENERAL MEDICAL STAFF MATTERS.**

5.1 **Emergency Preparedness Responsibilities.** Each Staff Member 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 Staff Member 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.

5.2 **On Call Response Time.** In order to assure timely medical care to patients presenting in the Emergency Department and nursing units, Practitioners providing on-call coverage must respond within fifteen (15) minutes of being contacted by the Emergency Department or nursing unit. If the Practitioner on-call is requested by the Emergency Room or nursing unit to treat a patient, the on-call Practitioner shall report to the Medical Center within a mutually agreed upon time period of being requested to do so. For an emergent request, the practitioner is expected to arrive within forty five (45) minutes unless otherwise agreed upon by all practitioners involved in the care.

5.3 **Failure to Respond.** Physicians who fail to accept or fulfill their obligations for ER back-up call shall be subject to corrective action.
5.4 **Personnel Authorized to Perform Medical Screening Examinations (Qualified Medical Persons).** Physicians and nurse practitioners and physician assistants are authorized to perform medical screening examinations for emergency medical conditions as outlined in the Advocate Aurora Health Care System policies.

For sexual assault victim patients, the medical screening exam may be performed by an Emergency Department Physician, Nurse Practitioner or Physician Assistant.

If a SANE performed the initial medical screen exam, a physician will further evaluate all sexual assault victim patients with any of the following conditions:

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

5.5 **Disclosure.** The Practitioner is accountable for disclosing unanticipated outcomes to the patient and family in accordance with the Advocate Aurora Health Care System Policies.

5.6 **Medical Staff Conduct.** All Staff Members shall refrain from disruptive, abusive and otherwise inappropriate conduct towards patients, employees, visitors, volunteers and other members of its medical staff. Staff Members will demonstrate reasonable expectations for professional conduct as outlined in the Aurora Medical Center Washington County Policy “Medical Staff Conduct Policy”.

6. **OTHER PROVISIONS.**

6.1 **Confirmation of Immunities, Releases and Confidentiality.**

6.1.1 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 Unified Medical Staff Bylaws, and any other written policies, procedures or directives of the Site Leadership Council or Unified 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 Unified Medical Staff Bylaws, or Medical Center policies and procedures regarding immunities, releases from liability, and confidentiality.

6.1.2 Any Medical Staff officer, Department Chair, 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 Unified Medical Staff Bylaws, and the Unified 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.

6.2 Construction. These Medical Staff Policies Governing Medical Practices, along with the Unified 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 Unified Medical Staff Bylaws.

6.3 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 Site Leadership Council and the Governing Board, in accordance with the Unified 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.

6.4 Adoption. These Medical Staff Policies Governing Medical Practices shall be subject to adoption and approval by the Site Leadership Council and shall be adopted and approved by the Governing Board.