Medical Staff Rules and Regulations
of
Aurora Medical Center of Washington County, Inc.

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

1.1 **Admitting Privileges.** Patients may be admitted to this Medical Center only by practitioners who have been appointed to the Medical Staff and granted admitting privileges in accordance with the Medical Staff Bylaws ("Practitioner"). Aurora Medical Center Washington County utilizes Advanced Practice Professionals (APP) as part of an Adult Inpatient Medical Service. APPs do not have admitting privileges, but may perform other Practitioner functions, as outlined in this document, per Wisconsin State statutes.

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

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

1.3 **Admitting Process.** For each Medical Center inpatient, the medical record must contain an admission order and note. Such documentation shall contain: (1) a concise statement of patient complaints, including the chief complaint; (2) the reason for admission for care, treatment and services, including the patient's initial diagnosis(es), diagnostic impression(s) or condition(s); (3) type and location of admission; (4) code status; (5) treatment goals and plan of care (plans of care and discharge plans should be initiated immediately upon admission and should be modified in the progress notes as patient care needs change); (6) any information related to the patient's condition, including but not limited to alcohol or drug use or mental illness as may be necessary to assure the protection of other patients, Medical Center personnel and Practitioners from patients who may be a source of danger to themselves or others; and (7) the name of the admitting and attending Practitioner. It is the expectation that the attending Practitioner or his/her designated alternate or independent health affiliate will provide the admission order within one (1) hour of the decision to admit the patient. If the attending Practitioner or his/her designated alternate cannot be reached to obtain the admission order within one (1) hour of the decision to admit the patient, the patient's care may be turned over to the first available person identified in the hierarchy below to obtain the admission order and for all additional care/treatment thereafter.

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

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

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

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

Emergency detention of patients with psychiatric diagnoses shall be handled in accordance with the Aurora Health Care System Policy Manual (Clinical & Administrative), “Behavioral Health Patients and the Emergency Detention and/or Protective Placement Process”.

1.5 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 of the decision to admit to intensive care as warranted by the patient’s condition.

1.6 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 APP, shall be performed on each patient admitted to the Medical Center. A preoperative diagnosis will be recorded prior to surgery.

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

In accordance with the Aurora Health Care System Policy Manual (Administrative/Clinical), “Informed Consent-Informed Refusal Policy”, the ordering or performing Practitioner or ordering or performing APP 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.
1.8 Patient Transfer.

1.8.1 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.

1.8.2 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.

1.8.3 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 APP must also ensure that: (1) the receiving facility has the capability to manage the patient's condition; (2) the receiving facility has consented to the admission and appropriate transfer arrangements have been made; (3) the patient is considered sufficiently stabilized for transport; and all pertinent medical information necessary to ensure continuity of care accompanies the patient to the receiving facility (including a Discharge Summary that includes the elements set forth in Section 3.10). The attending Practitioner or APP 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 APPs 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.

1.9 Patient Discharge. Patients shall be discharged only on the order of the discharging Practitioner or his/her alternate. It shall be the responsibility of the discharging Practitioner to discharge his/her patients on the day of discharge as early as feasible based on the patient’s condition. The attending Practitioner and/or appropriate designated personnel shall participate in discharge planning, utilizing the procedures outlined in the Aurora Health Care System Policy Manual (Administrative/ Clinical), “Discharge Planning Policy”. The attending Practitioner or appropriate advanced practice professional shall enter orders for any acute care, skilled services or hospice care required by the patient’s condition 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. The discharging Practitioner
must ensure that the patient or his or her representatives receives appropriate written
discharge instructions.

1.9.1 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, refer to the Aurora
and Transfer Policy”. (Above - section 1.8.3)

1.9.2 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.

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

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

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

1.11 Organ Donation. Every Practitioner is expected to comply with the
Aurora Medical Center Washington County Policy, “Organ and/or Tissue Donation - Nursing” in
order to facilitate compliance with federal and state legislation requiring that organ donation
requests be made of surviving family members of patients who expire and are suitable
candidates for organ donation.

1.12 Autopsy. It shall be the responsibility of all Practitioners and APPs 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 Aurora Health Care System Policy Manual (Administrative/Clinical), “Autopsy Policy”, 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. When an autopsy is performed the Practitioners involved in the patient’s care shall be notified.

1.13 Reportable Deaths.

1.13.1 Deaths Reportable to Medical Examiner. It is the initial responsibility of the attending Practitioner or designated alternate to report to the Washington County Medical Examiner’s Office and other applicable federal and state agencies deaths which occur in the Medical Center, that occur under any of the circumstances as outlined in the Aurora Health Care System Policy Manual (Administrative/Clinical), “Autopsy Policy”. In the event the attending Practitioner or designated alternate fails to make a timely report, any others with knowledge of these circumstances shall report the death.

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 Medical Executive Committee. In compliance with Aurora Health Care System Policy Manual (Administrative/Clinical), “Medication Formulary Process”, 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.

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 APP 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 Aurora Health Care System Policy Manual (Administrative/Clinical), “Abbreviations that are Unacceptable for Medical Record”, 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 or outpatient/ambulatory patients at the Medical Center.
2.3 **Patient's Medications from Home.** Patient use of medications brought from home is prohibited unless specifically ordered by the attending Practitioner or APP. Following identification of any medications brought from home by the patient, these medications should be returned to the patient's family or significant other for removal from the Medical Center. Refer to the Aurora Health Care System Policy Manual (Administrative/Clinical) on “Medication Brought into an Aurora Facility from an Outside Source”.

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

2.5 **Frequency of Patient Attendance.** All hospitalized patients will be seen on at least a daily basis by the attending Practitioner, or his or her designee. The attending Practitioner or APP shall document in the progress notes each patient attendance. If a progress note is entered by an advanced practice professional, 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 Medical Center as per the Aurora Medical Center Washington County policy *Ongoing Availability and Designation of Alternate Providers.*

2.7 **Consultations.** Any qualified Practitioner may be called for consultation within his or her area of expertise. The attending Practitioner or APP shall be responsible for requesting consultations when indicated. Consultation with the appropriate specialist should be considered under the following circumstances:

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

The Practitioner or APP requesting the consultation shall identify in the patient's medical record (1) the name of the specialty to be contacted; (2) the reason for the consult; (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. During this communication, the requesting Practitioner or APP and the consultant will agree upon a time frame within which the consultant will evaluate the stat patient. The requesting practitioner or nursing will contact the consultant for routine consults. Routine consults are generally expected to be provided no longer than twenty-four hours of being requested.

The consultant will render an opinion which will reflect, when appropriate the examination of the patient, review of the patient's medical record, and the consulting Practitioner's recommendations. This opinion must be part of the medical record.

2.8 Critical Test Values. All critical results/values of tests and diagnostic procedures are promptly reported and documented in accordance with Aurora Health Care System Policy Manual (Administrative/Clinical), “Critical Results and Values Reporting”. 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 Practitioners and APPs of critical values. The Practitioner or APP receiving the critical test values will read back the critical lab values back to the caller to verify accuracy.

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 Restraints and Seclusion. Use of restraints and/or seclusion must be initiated and continued in accordance with the current Aurora Health Care System Policy Manual (Administrative/Clinical), “Restraints Policy”.

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

2.13 Mechanism for Handling Concerns about Patient Care. If a nurse or other healthcare professional involved in the care of a patient has any reason to doubt or question the care provided to that patient, or feels that appropriate consultation is needed and has not been obtained, such individual shall follow the procedures as outlined in the Aurora Health Care System Policy Manual (Administrative/Clinical), “Incident Reporting/Sentinel Event Management Policy”. If warranted, the matter may be brought to the attention of the Chair of the Department 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 leader consulted is responsible for proper evaluation of the situation. The leader shall report to the director of the area and the attending physician the evaluation of the patient’s condition and action ordered to ensure proper care. If there is an inordinate delay in Medical Staff action, the appropriate administrator should be notified promptly.
2.14 **Research Protocols.** Research involving use of investigational treatments, procedures, and/or medications must be reviewed and approved by the Aurora Health Care Institutional Review Board (IRB) and comply with the policies and procedures set forth by the IRB including informed consent. Copies of the research protocol and informed consent must be included in the patient’s medical record.

3 **MEDICAL RECORDS.**

3.1 **Components.** The medical record must be maintained as set forth in the Aurora Health Care System Policy Manual (Administrative/ Clinical), “Medical Record Documentation Policy” and the AMCWC 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 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, in accordance with the Aurora Health Care System Policy Manual (Administrative/ Clinical), “Informed Consent/Informed Refusal Policy”.

3.6 **Requirements for History and Physical Examinations.**

**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 Bylaws, Rules and Regulations and Medical Staff policies.

**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; 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.

**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.

**Pre-Admission H&Ps and Updates.** An H&P performed by a qualified physician or advanced practice 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 practitioner 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.

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;
- 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
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;
- 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 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.

3.7 **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).
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- **Pre-Sedation Assessment** shall be present on the medical record prior to any administration of minimal or moderate sedation. In all other cases, a History & Physical exam must be present.
- Patient's written informed consent
- Consultation reports as relevant
- Results of all relevant laboratory, EKG and x-ray studies. In most instances, laboratory, EKG and x-ray results are acceptable if they have been obtained within thirty (30) days prior to the procedure. However, it may be necessary to obtain certain imaging or laboratory results within shorter time periods (e.g., pregnancy tests must be performed immediately prior to surgery, and coagulation tests should be performed as close to the date of surgery as possible).

3.8 **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.

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

3.9.1 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.

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

3.9.3 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.

3.9.4 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.

3.10 Discharge Summary. The attending Practitioner or APP is responsible for ensuring that a Discharge Summary is entered or dictated within fourteen (14) days after discharge. Discharge Summaries by APP’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 APP 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.

3.11 **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.

3.12 **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.

3.13 **Maternity Records.** Except in an emergency, before a maternity patient may be admitted, the patient's attending Practitioner must submit a legible copy of the prenatal history to the Medical Center's obstetrical staff. The prenatal history shall note pregnancy-related complications, Rh determination, and any other matters essential to adequate care of the maternity patient.
3.14 **Restraints and Seclusion.** The medical record must contain required documentation regarding the use of restraints or seclusion, as specified in the Aurora Health Care System Policy Manual (Administrative/ Clinical), “Restraints Policy”.

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 Medical Executive Committee.

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 Aurora Health Care System Policy Manual (Administrative/Clinical), “Use and/or Disclosure of Protected Health Information”.

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

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

The Medical Staff and Medical Affiliates participate in an organized arrangement with Aurora Health Care, Inc. ("Aurora"). Participation means the Medical Staff and Medical Affiliates agree, when present at an Aurora Facility, to abide by the privacy policies and practices as outlined in the Aurora Health Care System Policy Manual (Administrative/Clinical), “Confidentiality Information Privacy Policy”. Participation also means such notice, when provided to the patient with the patient's acknowledgment (unless an exception applies), meets federal notice requirements for both the Practitioner and Aurora for care provided at an Aurora facility.

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

4 **OPERATIVE AND INVASIVE PROCEDURES.**

4.1 **Anesthesia** means the administration (in any setting, by any route, for any purpose) of general, spinal, or other major regional anesthesia or sedation, with or without analgesia, for which there is the 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
4.2 Operative and Invasive Procedures means procedures involving the puncture or incision of the skin or insertion of an instrument or foreign material into the body including, but not limited to any procedures performed in the operating room, any procedure in which moderate or deep sedation or anesthesia is used, or any of the following, even if sedation is not used:

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

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

4.3 Surgical Site Marking. Marking of the surgical site shall be performed in accordance with Aurora Health Care System Policy Manual (Administrative/Clinical), “Procedural Safety Policy”.

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

4.5 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 Practitioner in charge of the overall medical direction of the emergency preparedness plan. This would include, but not necessarily be limited to, cases of evacuation of patients from one section of the Medical Center to another or from the hospital premises entirely.

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

5.2 **On Call Response Time.** In order to assure timely medical care to patients presenting in the Emergency Department 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 thirty (30) minutes.

5.3 **Failure to Respond.** Practitioners who fail to accept or fulfill their obligations for Emergency Department Call Coverage as outlined in the Aurora Medical Center Washington County Policy, “Call Coverage Policy” shall be referred to the Practice Evaluation Committee.

5.4 **Personnel Authorized to Perform Medical Screening Examinations (Qualified Medical Persons).** Practitioners and mid-level providers are authorized to perform medical screening examinations for emergency medical conditions as outlined in the Aurora Health Care System Policy Manual (Administrative/ Clinical), “EMTALA: Screening, Stabilization and Transfer Policy”.

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 Medical Center, “Expanded Role of the Nurse in the Emergency Department Policy”.

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

If a SANE performed the initial medical screen exam, a practitioner 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 of 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 Aurora Health Care System Policy Manual (Administrative/Clinical), “Disclosure of Unanticipated Outcomes Policy”.

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 Adoption. These Medical Staff Rules and Regulations shall be subject to adoption procedures set forth in the Medical Staff Bylaws section 10.2, policies governing medical practices.

6.2 Amendment Process. Amendments of these Rules and Regulations shall be in accordance with the process set forth in the Medical Staff Bylaws section 10.2, policies governing medical practices.

6.3 Effective Date. Any amendments to these Medical Staff Rules and Regulations adopted and approved by the amendment process outlined in the Medical Staff Bylaws shall become effective only when approved by the Governing Board.