## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission and Discharge of Patients</td>
<td>2</td>
</tr>
<tr>
<td>Admissions to the Intensive/Coronary Care Unit</td>
<td>3</td>
</tr>
<tr>
<td>Patient Transfers</td>
<td>4</td>
</tr>
<tr>
<td>Consents</td>
<td>4</td>
</tr>
<tr>
<td>Deaths</td>
<td>5</td>
</tr>
<tr>
<td>Medical Records</td>
<td>6</td>
</tr>
<tr>
<td>General Conduct of Care</td>
<td>12</td>
</tr>
<tr>
<td>General Rules Regarding Surgical Care</td>
<td>14</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>16</td>
</tr>
</tbody>
</table>

Revised: 4/20/17
ADMISSION AND DISCHARGE OF PATIENTS

A. All patients shall be admitted to the hospital by a member in good standing of the Medical Staff; the patients of other practitioners granted admitting privileges under the Medical Staff Bylaws shall be admitted and discharged in accordance with the privileges so granted.

B. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital within 24 hours of admission for all patients, except ICU patients who must be seen within 12 hours of admission. Medical staff members are also responsible for the prompt completeness and accuracy of the medical record, for necessary special instructions and for advising relatives of patients concerning their condition.

C. Orders for consultations shall be entered in the EHR, or prior to EHR implementation, written on the order sheet of patient records and shall direct the consultant, as appropriate, to (1) see the patient and advise on a specified problem; (2) see the patient and follow the care of a specified problem as long as necessary; or (3) assume complete responsibility for the care of the patient.

D. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated.

E. In any emergency case in which it appears the patient will have to be admitted to the hospital, the practitioner shall, when possible, first contact the nursing supervisor on duty.

F. The practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the medical staff and the Administration of the hospital, that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's record as soon as possible after admission.

G. When a patient who does not have a personal physician is admitted because of an emergency, the patient may request any physician on the medical staff as his or her attending physician. When the patient has no preference, a member of the active medical staff on the appropriate emergency call list shall be assigned to the patient. The emergency call list shall contain individual names, rather than group names, of those individuals assigned to provide emergency call coverage. If the assigned staff member is unable to attend the patient, he shall arrange within a reasonable time, as dictated by the patient's condition, for the reassignment and disposition of the patient. When difficulty is encountered in making a suitable assignment or reassignment, the staff member in charge of the Emergency Department, or if he/she is unavailable, the President of the Medical Staff, Chairman of the Service Committee or any member of the Medical Executive Committee may be notified and may arrange for the assignment and disposition of the patient.
H. The emergency department physician will contact the physician listed on the call schedule if a patient requires further assessment or stabilizing treatment. The on-call physician may send a licensed non-physician practitioner as his or her representative to appear at the Hospital and assess or treat the patient. Ultimately, however, it is the responsibility of the designated on-call physician to provide the necessary services to the patient, regardless of who makes the in-person appearance. In the event the emergency department physician disagrees with the on-call physician’s decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required to appear in person.

I. Any practitioner who will be unable to respond to emergencies within thirty (30) minutes because of the distance from his residence to the hospital, shall designate another member of the staff (“Substitute Physician”) who will ordinarily be able to respond to emergencies within thirty (30) minutes and who has agreed to attend his patients when emergencies occur. Whenever a designee is not named or the designee is unavailable, the Chief Executive Officer, the President of the Medical Staff or the chairman of the appropriate committee may request any member of the medical staff to attend the physician’s patients in an emergency. For purpose of this section, an “emergency” is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger.

J. On call physicians may be on simultaneous call at another hospital or perform elective surgeries while on call. The on call physician shall attempt to identify a Substitute Physician who can respond to emergencies in the event that the on call physician is unable to respond to an emergency call within thirty (30) minutes because he or she is taking simultaneous call or performing an elective surgery. If an on call physician is unable to identify a Substitute Physician and a patient is in need of emergency services in the on-call physician’s specialty, the patient will be transferred according to Hospital’s policies.

K. Patients shall ordinarily be discharged only on an order of the attending physician or other practitioner granted the privilege of discharging a patient under the Medical Staff Bylaws. When this is not possible, an explanation shall be made in the patient’s medical record.

L. Responsibility for Medical Care: Each patient shall be the responsibility of a member of the Medical Staff, who has the appropriate privileges.

ADMISSIONS TO THE INTENSIVE/CORONARY CARE UNIT

A. If any questions as to the appropriateness of admission to or discharge from the Intensive/Coronary Care Unit should arise, a determination of appropriateness shall be made through consultation with the Service Committee Chairman in charge of the Intensive/Coronary Care Unit, the President of the Medical Staff or any member of the Medical Executive Committee.
PATIENT TRANSFERS

A. Transfer priorities shall be as follows:
   1. Emergency situation to appropriate patient bed.
   2. From Intensive/Coronary Care Unit to general care area.
   3. From temporary placement in an appropriate geographic or a clinical service area to the appropriate area for that patient.

B. Ordinarily, no patient will be transferred without such approval of the attending practitioner. However, if there is a shortage of appropriate beds, the President of the Medical Staff, Service Committee Chairman or any member of the Medical Executive Committee shall have authority to decide which patients shall be transferred.

C. Whenever the admitting practitioner has reason to believe a patient may be a danger to himself or others, he shall provide the hospital information necessary to allow protection of the patient and others.

D. Medical screening examinations of emergency patients to rule out the presence of an emergent condition may be performed by an Emergency Department physician's assistant who has demonstrated competency through training and skills verification, a nurse practitioner who has demonstrated competency through training and skills verification or a physician. Medical screening examination of patients who present to the OB Department to determine whether the patient is in active labor may be performed by a registered nurse who has demonstrated competency through training and skills verification, a certified nurse midwife, or a physician. (Revised 4/17/01)

CONSENTS

A. A Conditions of Registration form, signed by every patient admitted to the hospital, or his representative, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper informed consent before the patient is treated in the hospital.

B. Informed Consents - Informed consent to examine and/or treat shall be obtained by the Licensed Independent Practitioner (LIP) prior to examination or treatment for the following, except in those situations where the patient's life is in jeopardy and consent cannot be obtained due to the condition of the patient.
   1. Surgery, which involves an entry into the body through an incision or through one of the natural body openings, excluding vaginal childbirth.
   2. Invasive procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to percutaneous aspiration, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, but excluding venipuncture and intravenous therapy.
3. Administration of blood/blood products
4. When determined to be appropriate by LIP.

In emergencies involving a minor as defined by the statute for medical treatment, or involving an unconscious patient for whom consent cannot be immediately obtained from parents, guardians, or next of kin, the circumstances should be noted on the patient's medical record.

Documentation of informed consent can be done on the Legacy consent form, a form of your own choosing or in the H&P, and must include the following information:
   (a) Name of patient, and when appropriate, patient's legal guardian,
   (b) Name of hospital,
   (c) Name of procedure/treatment
   (d) Name of responsible practitioner(s)
   (e) Statement that the procedure/treatment was explained to the patient or authorized consenter
   (f) Signature of the patient or authorized consenter
   (g) Date and time the form is signed by the patient or authorized consenter
   (h) Name/signature of person who conducted and documented the informed consent.

C. Should a second operation be required during the patient's stay in the hospital, a second specific informed consent shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, consent may be documented on one form.

D. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

DEATHS

A. Within a reasonable time after a hospital death, the deceased shall be pronounced dead by the attending physician or his designated physician or registered nurse. The body shall not be released until an entry has been made, dated, timed, and authenticated in the medical record of the deceased by the attending physician or designee. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease, wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to applicable law.

B. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with Oregon law. All autopsies shall be performed by a hospital pathologist or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within
48 hours and the complete protocol should be made a part of the record within two months to be reviewed by the appropriate service committee.

C. At the discretion of the attending physician after discussion with the hospital pathologist, the following circumstance may suggest the need for autopsy:

1. A patient who expires within 24 hours of admission without being seen by a physician.
2. A patient whose demise is unexpected and whose cause of death is clearly undetermined.
3. A patient who dies under suspicious circumstances.
4. A question or concern relative to the diagnosis by the physician or family members.

MEDICAL RECORDS

A. Electronic Health Record Use and Responsibilities

Legacy’s electronic health record (EHR) system has the potential to offer many advantages over paper records, including improving the quality of care for patients, reducing medical errors, promoting best practices, and decreasing the cost of care. Like all new technology, however, the EHR, if used improperly, could potentially result in medical errors and patient harm. The purpose of these rules is to set forth the expectations of the Medical Staff for the proper use of the EHR in order to ensure patient safety and high quality health care. Once the EHR is implemented, practitioners will actively and meaningfully use the EHR for all patients for whom they care for in the Hospital. Practitioners document all patient encounters in the EHR in a prompt and timely manner, and in all cases within the time frames as required by law and set forth in these Rules and Regulations. Practitioners must complete EHR documentation within the times frames required by law and these Rules & Regulations.

B. Demonstration of Competency

A Practitioner will be granted access to the EHR once the Practitioner demonstrates that he/she can utilize the system in the Hospital in a competent, safe and effective manner. Basic competence is defined as the role-specific ability of any Practitioner to perform his/her usual work flows in the care of the patient, including the specific components below. The Hospital will provide appropriate basic competency training for all Practitioners.

Periodic upgrades in EHR technology, structure or process may necessitate that Practitioners complete additional training in order to remain competent in use of the EHR. EHR training deemed necessary by Legacy Health for the safe and efficient operation of the EHR system shall be reviewed and approved by the MEC EHR training approved by the MEC shall be mandatory for designated practitioners.
1. **Computer Practitioner Order Management**
   All clinicians will use Computer Practitioner Order Management (CPOM) for entering orders into the EHR. Verbal orders (including telephone orders) will only be given in urgent situations, when immediate access to CPOM is not feasible and orders are needed promptly to address changes in the patient’s condition. All verbal orders must be dated, timed and authenticated as required by law and these Rules & Regulations.

2. **Problem List Maintenance**
   Practitioners will update the active Problem List, within the scope of their clinical expertise, at each clinical encounter. The Problem List is for the acute and/or chronic active problems of the patient. An accurate and up to date Problem List in the EHR is essential for ensuring safe and high quality patient care.

3. **Medication Management**
   Practitioners will update the Discrete Medication List at each clinical encounter. All medications, including PRN medications available for current use, chronic OTC medications, vitamins, supplements, homeopathic remedies, medications prescribed for chronic use by non-Legacy practitioners, should be on the Discrete Medication List. Duplicate medications should be removed from the Discrete Medication List.

4. **Online Results Retrieval**
   Inpatient practitioners will utilize the online results retrieval in the EHR and communicate results to patients in a timely manner.

C. **Failure to Properly Use the EHR**
A Medical Staff appointee must properly use the EHR as set forth in these Rules. After notice from the Medical Staff for failure to properly use the EHR and an opportunity to come into compliance, a Medical Staff appointee’s admitting and clinical privileges (elective and emergency) shall be deemed to be automatically relinquished, for failure to comply. Clinical privileges shall be formally reinstated once the appointee (1) meets the requirements established by Legacy Information Services for EHR training and demonstration of competency and (2) agrees in writing to properly use the EHR as set forth in these Rules. Failure to complete training, demonstrate competency and agree to properly use the EHR within sixty (60) days from the date privileges were relinquished shall constitute an automatic relinquishment of all admitting and clinical privileges and voluntary resignation from the Medical Staff.

D. **Emergency Department Records**
Emergency Department, outpatient and clinic records shall be maintained and available to the other professional services of the hospital. These records shall include identification data, chief complaint, a brief history of the disease or injury treated, physical findings, laboratory and radiology reports, reports on any special examinations, diagnosis, record of treatment, disposition of case, instructions to the patient, a copy of the pre-hospital report form (when a patient is brought in by ambulance), the signature or authentication of the attending
practitioner and signed consents for surgery, anesthesia, other procedures involving substantial risk (or the reason consent was not obtained) and the report of any autopsy. All entries should be dated, time, and authenticated.

E. Components of a Complete Record
Complete, legible medical records shall be maintained for every inpatient. Their contents shall be pertinent and current. These records shall include identification data, chief complaint, details of the present illness, pertinent family and personal history, inventory by body systems, physical examination, special reports including clinical laboratory reports, reports on special examinations, radiology reports and reports of consultants, orders of practitioners acting within the scope of their professional license, dated progress notes, appropriate graphic charts or personnel notes, discharge summary, autopsy report if applicable and signed consents for surgery, anesthesia and other procedures involving substantial risk (or the reason consent was not obtained). Records of surgical patients shall also include a pre-operative history and physical examination and diagnosis recorded prior to operation; anesthesia records; a record of operation documented following surgery, including a complete description of the operation procedures and findings, post-operative diagnostic impression and a description of the tissue and appliances if any, removed; and a pathology report is completed. All entries should be dated, time, and authenticated.

F. History & Physical
An admission history and physical (H&P) including a medical history, physical examination report and provisional diagnosis will be completed and placed in the patient’s medical record no more than 30 days before or within 24 hours after admission (or prior to an invasive procedure requiring sedation, whichever comes first). The H&P will be completed by a practitioner who has been granted privileges to do so. The H&P will be completed within 24 hours of admission or prior to an invasive procedure requiring sedation (as defined by the medical staff), whichever comes first. The H&P is completed within 24 hours of an ambulatory invasive procedure requiring sedation. Once the H&P is completed for an inpatient, it does not need to be repeated or updated for invasive procedures, as long as the patient remains an inpatient.

If the procedure requires only a local anesthetic and no sedation, then an H&P does not need to be completed. Sedation is defined as ANY medication given for anti-anxiety or sedation via ANY route. This includes po, IV, IM, IN, PR, SQ. A patient may take his or her own prior to the procedure; however, if a medication is ordered and removed from the Pyxis for the purpose of sedation or anti-anxiety, then an H&P is required.

If an H&P was completed within 30 days before admission or an invasive procedure requiring sedation, such as in the office of a physician staff member, a durable, legible copy of the H&P may be used in the patient’s medical record. The practitioner entering such a copy will date and sign it. When using an H&P that was performed prior to admission or an
invasive procedure requiring sedation, the patient’s condition will be assessed within 24 hours after admission or prior to an invasive procedure requiring sedation, whichever comes first, and the assessment documented in the medical record. Documentation must include any changes in the patient’s condition since the H&P was completed or no changes in the patient’s condition since the H&P was completed. Documentation must include the time, date and practitioner signature. Prior to implementation of the EHR, documentation must also include the provider number.

For all inpatients and ambulatory patients undergoing procedures, the following content for the H&P is required; chief complaint, present illness, past history, review of all systems, physical examination, impression and plan. These expectations may vary by setting or level of care, treatment and service but will produce sufficient information to provide the care and services required to address the patient’s conditions. There will be a pre-sedation assessment and a second assessment immediately prior to induction for all patients receiving sedation in accordance with LHS.900.2311 Care of the Patient Receiving Sedation for Diagnostic, Therapeutic or Surgical Procedures.

When the history and physical examination are not recorded or updated before an operation or invasive procedure or any diagnostic procedure involving substantial risk, referring to diagnostic procedures that require sedation, the procedure shall be canceled unless the attending practitioner states in writing or via entry in the EHR that such delay would be detrimental to the patient.

G. Progress Notes
Pertinent progress notes sufficient to permit continuity of care and transferability shall be recorded at the time of observation. The condition of the patient and the practitioner’s judgment determine the frequency with which they are made.

H. Operative Reports
Reports of operations shall include a detailed account of the surgical findings and of surgical technique. Reports of operations shall be entered in the EHR, or prior to implementation of the EHR, written or dictated immediately following surgery for all patients. The report shall be promptly dated, timed, and authenticated by the Licensed Independent Practitioner (LIP) responsible for the patient, when indicated diagnostic tests have been completed and recorded. For emergency situations in which there is inadequate time to record the history and physician examination before surgery a brief note including the preoperative diagnosis, is recorded before surgery.

The operative report shall include the following:

- Name of Licensed Independent Practitioner and assistants
- Name of procedure
- Findings
- Procedure performed and description of the procedure
- Technical procedures used
Specimens removed
Estimated blood loss, as indicated
Post-operative diagnosis
Disposition of each specimen if not noted elsewhere.

When an operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.

I. Consultations
Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

3. Authentication
All record entries shall be timed and dated, author identified and authenticated when necessary. Prior to implementation of the EHR, authentication of an entry must ensure that the practitioner is identifiable through the use of one of the following: the P number, printed signature or stamped signature or stamped signature with P number. Authentication may include written signatures, initials defined on a signature page or by signature stamps or computer signatures when authorized users of signatures of signature stamp or computer keys sign statement assuring that they alone will use the stamp or key.

4. Abbreviations
The current list of prohibited abbreviations or symbols is posted on the nursing units, in the clinics and in records as an insert and will be updated as needed. Compliance with LHS policy 700.12 - Approved Abbreviations and Do Not Use List, is required for all medical staff and employees of Legacy Health System.

5. Final Diagnosis
Final diagnosis shall be recorded in the patient record. Unless revised by the discharging physician, the final diagnosis will be the principal hospital problem as defined on the problem list on the day of discharge. If the LIP revises the final diagnosis, symbols and abbreviations, may not be used.

6. Discharge summary
Discharge summary (clinical resume) shall be entered in the EHR, or prior to EHR implementation, written or dictated on all medical records of patients hospitalized 48 hours or more. The clinical resume should include the following:
1. Provisional diagnosis or reasons for admission.
2. Principal and additional or associated diagnoses.
3. Significant findings.
4. Procedure performed and treatment rendered.
5. Condition of the patient on discharge.
6. Any instructions given to the patient and/or family, as pertinent.

7. Final Progress Note
A final progress note may be substituted for the resume in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization. The final progress note must include the final diagnosis recorded in full either on the face sheet, final progress note, or discharge summary for all patients, the outcome of hospitalization, the disposition of the case, and the provisions for follow up care. Symbols and abbreviations may not be used.

8. Documentation of Death
In the event of death, a summation statement should be added to the record either as a final progress note or as a separate resume. This final note should indicate the reason for admission, the findings, course in the hospital and events leading to death.

9. Access to Medical Records

1. Records may be removed from the hospital’s jurisdiction and safekeeping only in accordance with hospital policy, a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away.

2. In the case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same physician or by another.

3. Unauthorized removal of records from the hospital is grounds for disciplinary action.

4. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research. Research plans shall provide for confidentiality of personal information and shall conform with applicable law. All such projects shall be approved by the Medical Executive Committee and a Human Research Committee, if appropriate, before records can be studied.

5. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

10. Medical Record Completion
The completion of medical records shall be the responsibility of attending practitioners. Dentists, clinical psychologists, podiatrists or other individuals acting within the scope of
professional licenses shall complete those portions of records which pertain to their care of patients. The appropriate individuals shall date, time, sign or authenticate the history and physical examination, report of operation, progress notes orders, clinical laboratory reports, radiology reports, reports of consultants, reports on special examinations, final diagnosis and discharge summary or final progress notes. Practitioners acting within the scope of their professional licenses shall sign any clinical entries which they make themselves.

A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff President.

Practitioners will be notified of incomplete records by mail. A notice will list records that are incomplete. Practitioners not completing records within 30 days of discharge will be placed on the No Admit list. Placement on the No Admit list will result in automatic suspension in the form of withdrawal of admitting (except emergencies), or other related privileges, including scheduling, assisting in surgery, and administering anesthesia. Practitioners staffing the ED are not excluded from suspension of privileges due to delinquent charts. Automatic suspension will remain in effect until the delinquent medical records are completed and the suspension has

11. Disclosure
A current policy on the use and disclosure of Protected Health Information, including access of patients to their medical records is available in Health Information Services and on line LHS. 700.18, Use and Disclosure of Protected Health Information

GENERAL CONDUCT OF CARE

A. All orders for treatment shall be entered in the EHR or, prior to EHR implementation, in writing. However, practitioners acting within the scope of their licenses may give emergent verbal orders (including telephone orders) if they are authorized to give orders. Verbal orders shall be considered to be in writing if given to a duly authorized person acting within the scope of their license. Verbal orders must be signed, dated and timed by the practitioner who is responsible for the care of the patient, within 48 hours of when the order was given.

All verbal orders, including those dictated over the telephone, shall be signed by the person to whom they are given and shall state the name of the practitioner who gave the order. The following persons are authorized to receive verbal orders:

- Registered nurses
- Licensed practical nurses
- Utilization review analysts relating to admission status
Laboratory, radiology, nuclear medicine, ultrasound, dietary, cardio-respiratory, pharmacy, physical therapy, occupational therapy and speech pathology staff, and clinical resource coordinators (CRC) functioning within their sphere of competence when approved by their department head. Unlicensed (e.g. CNAs) and clerical personnel (e.g. admitting personnel and unit secretaries) are NOT authorized to accept and document verbal orders.

- Medical Assistants
- Physician Assistants
- Perfusionists
- Genetic counselors
- LVNA LCSWs and MSWs may accept orders for medical social work services
- Ophthalmic technicians

In the Legacy Clinics orders may be accepted by RNs, LPNs and MAs functioning within their competencies when approved by the medical director.

B. Orders: Orders must be entered in the EHR or, prior to EHR implementation, written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until understood by the nurse. Orders may be utilized in the following formats:

1. Protocols – Medically directed care (set of linked orders) for a specific diagnosis, emergent condition, procedure, treatment or symptom. Protocols include: medications, treatments, diagnostic testing, monitoring and assessment parameters in response to a patient’s condition. Except in emergency situations, protocols are initiated by an order from a credentialed practitioner who is authorized to give orders. Protocols are developed and approved by specific departments or programs with input from physicians and approved by the Medical Executive Committee. Protocols containing medications must be approved by the Medication Use Committee.

2. Preprinted Orders - Preprinted orders will be documented on an order sheet and do not require approval of the Medical Executive Committee. Preprinted orders will be utilized for specific practitioners and for a specific diagnoses. Preprinted orders will be modified, as appropriate, for individual patients, and are initiated by an order from a credentialed practitioner who is authorized to give orders. Preprinted orders containing medications must be approved by the Medication Use Committee.

3. Standing Orders - Standing orders, order sets and protocols may be used only as permitted by federal and state law. Such orders and protocols must be: (i) reviewed and approved by the medical staff and nursing and pharmacy leadership; (ii) consistent with nationally recognized and evidenced based guidelines; (iii) periodically and regularly reviewed; and (iv) dated, timed and authenticated promptly by the ordering practitioner or by another practitioner responsible for the care of the patient.

C. All previous orders are canceled when patients go to surgery, transfer from ICU to the ward, or transfer from the ward to ICU.
D. A method shall be established to control the use of drugs. All medications shall be administered by or under the supervision of appropriately licensed personnel within the scope of their license in accordance with applicable law and regulations governing such acts and in accordance with medical staff bylaws and hospital policies and procedures.

E. The method for control of drugs brought into the hospital by patients shall be as defined in LHS.900.2240.

F. Except in an emergency, consultation should be obtained in the following situations:

1. When the patient is not a good risk for operation.
2. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
3. Where there is doubt as to the choice of therapeutic measures to be utilized.
4. In unusually complicated situations where specific skills of other physicians may be needed.
5. When requested by the patient or his family.

G. Consultation Requests: Attending practitioners are primarily responsible for requesting consultations. The nursing staff will make reasonable efforts to assist them in obtaining consultations. Ordinarily, an order authorizing a consultation shall be entered in a patient's medical record before a consultant attends or examines a patient.

GENERAL RULES REGARDING SURGICAL CARE

A. Except in emergencies, the pre-operative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

B. Surgical procedures performed by dentists and podiatrists shall be under the supervision of the Chairman of Surgery Services Committee or his designee. Podiatrists may be granted the privileges to admit their patients to the inpatient setting. Patients admitted as an inpatient for services by a dentist or podiatrist shall be under the joint care of a physician.

1. A dentist or podiatrist shall be responsible for the following:
   ✓ A detailed dental or podiatric history justifying hospital admission.
   ✓ A detailed description of the dental or podiatric examination and pre-operative diagnosis.
   c). A complete operative report describing the findings and technique. When teeth are extracted, the report shall state the number of teeth and fragments removed.
2. A physician shall be responsible for the following:
   a). An admission history, a physical examination and an evaluation of the overall medical risk.
   b). Care of any medical problem that may be present at admission or that may arise during hospitalization of any dental or pediatric patient.

3. An oral surgeon shall be responsible for the following:
   a). An admission history, a physical examination and an evaluation of the overall medical risk,
   b). Obtaining consultation from a physician for any medical problem that may be present at admission or that may arise during hospitalization.

C. **Anesthesia Record:** The anesthesiologist shall maintain a complete anesthesia record to include documentation of pre-anesthetic evaluation, time of anesthetic and surgery, fluid replacement and blood and post-anesthetic follow-up of the patient’s condition. Compliance with discharge criteria is documented. Post-operative documentation records any unusual events or complications or the management of such events as well as the name of the licensed independent practitioner responsible for discharge.

The anesthesia record will be completed for any patient undergoing general, spinal or other major regional anesthesia. The post-anesthesia note may be delegated to another physician with anesthesia privileges.

D. Ordinarily, the decision to use another physician or oral surgeon as an assistant in surgery shall be within the discretion of the surgeon responsible for the case. Disputes about the appropriate use of assistants shall be brought to the attention of the Physician Advisor for Surgery.

E. Tissue removed during an operation, including teeth and fragments of teeth, shall be sent to the hospital pathologist for tissue diagnosis, unless such tissue is deemed an exception by the surgical services committee, and according to current policy for handling of surgical pathology specimens.

F. If the practitioner refers tissue or other specimens to another laboratory without going through the hospital laboratory, he must document where the specimen has gone and must assure that the report is back on the record in a timely manner.
EMERGENCY SERVICES

A. The attending practitioner will assume responsibility at the time of admission for the care of patients admitted from the Emergency Department.

B. If clinical indicated, patients (a) seen in the Emergency Department by the on-call physician or (b) referred by the Emergency Department to the on-call physician will be scheduled for at least one follow up visit, regardless of the patient’s ability to pay, for the problem which precipitated the initial visit to the Emergency Department. This obligation ends if the patient does not contact the physician’s office within two (2) weeks of the Emergency Department visit to request an appointment. Further aftercare may be referred elsewhere at the discretion of the physician.

6/18/01 edition

To LHS Board
Approved 04/19/85
Approved 03/24/86
Approved 10/20/86
Approved 12/21/89
Approved 12/02/91
Approved 03/04/92 inclusion of oral surgeons
Approved 10/07/92 who can give medications
Approved 12/06/93 H&Ps w/in 30 days & ED patient follow-up by physician's office
Approved 09/12/94 add Allied Health Professionals, change to “practitioner” according to Bylaws definition, cross-reference policy for surgical lab specimen exceptions.
Approved 02/15/98 add procedure clarification for no-admit issue
Approved 04/13/98 Defined time frames in which patients must be seen by attending, added consent clarification, added protocols, preprinted and standing orders, and added clarification of anesthesiologist responsibility for documentation
Approved 02/18/99 regarding oversight of medical students and residents
Approved 11/18/99 add persons authorized to accept verbal orders.
Approved 07/20/00 Medical Records, section W – clarifies 30 day completion requirement, adds reference to anesthesia, E.D.
Approved 04/17/00 PATIENT TRANSFERS – add medical screening MEDICAL RECORDS – H&Ps GENERAL CONDUCT OF CARE – orders EMERGENCY – delete procedures for E.R. Call/ case review EXPENDITURE OF FUNDS – delete
Approved 06/21/01 delete oversight of medical students and residents (moved to policies)
Approved 04/18/02 add Utilization Review Analysts to General Conduct of Care A.
To LHS Board Approved 05/12/03 delete (registered clinical social workers) under Utilization Review Analysts to General Conduct of Care.

To LHS Board Approved 05/20/04 consent, medical records, orders and Ethics Committee.

To LHS Board Approved 07/18/05 update language, consent form and H&P

To LHS Board Approved 09/21/06 update consent form, H&P, P number requirement

To LHS Board Approved 03/15/07 update language to H. Operative report and Admitting procedures

To LHS Board Approved 04/19/07 update consent form language. Added: procedure side, risks, potential problems

To LHS Board Approved 05/17/07 Medical Records C. History and Physical language rev

To LHS Board Approved 07/19/07 Consents form rev - CMS Interpretive Guidelines

To LHS Board Approved 11/15/07 Medical Records H&P language rev; Verbal Orders-CMS Guidelines

To LH Board Approved 04/17/08 Standing Orders rev

To LH Board Approved 01/21/10 AHP ER Call added

To LH Board Approved 02/18/10 Verbal orders rev

To LH Board Approved 08/18/11 EHR language – EPIC implementation and reorganized format

To LH Board Approved 01/17/13 Medical Screening examinations of emergency patient = NP

To LH Board Approved 01/17/13 Final Diagnosis

To LH Board Approved 04/17/14 EHR language – mandatory basic competency for EPIC

To LH Board Approved 04/16/15 EHR language –Failure to properly use the EHR & Standing Orders

To LH Board Approved 08/20/15 Revision to Emergency Services language

To LH Board Approved 12/14/15 Revision to Medical Records Completion

To LH Board Approved 04/20/17 Podiatry inpatient admissions

To LH Board Approved 12/21/17 H&P prior to sedation for IR procedures