SACRED HEART-SAINT MARY'S HOSPITALS, INCORPORATED

RULES, REGULATIONS AND POLICIES

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SACRED HEART-SAINT MARY'S HOSPITALS, INCORPORATED

RULES, REGULATIONS AND POLICIES

A: ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a member of the Medical Staff with admitting privileges. If the member is not a physician, a physician member must be designated to be responsible for the medical aspects of care. All Practitioners shall be governed by the official admitting policy of the Hospital.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and authorized relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3. Except in emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. A brief and informative note must be on the chart within 24 hours of admission.

4. Each Practitioner must assure timely, adequate professional care for his/her patients in the Hospital by being available or having available an eligible alternate Practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure to meet these requirements can result in the loss of clinical privileges. As a courtesy to the patient(s), the Practitioner is advised to inform them of the alternate.

5. The Medical Staff shall define the categories of medical conditions and criteria to be used to establish priorities for and review of Hospital cases. These shall be developed by the clinical Services and committees.

6. The admitting Practitioner shall be responsible for providing the appropriate Hospital staff with such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patient might be a source of danger.

7. Questions as to the advisability of admission to or discharge from a critical care unit should be resolved through consultations with the Chairman of the appropriate Service.

8. At Sacred Heart Hospital, any patient known or suspected to be emotionally or psychiatrically unstable may be admitted for emergency management. At Saint Mary's Hospital, any patient known or suspected to be emotionally or psychiatrically unstable may be admitted to or transferred to the Ministry Behavioral Health Inpatient Unit. The attending Practitioner is responsible for the management of the patient by whatever chemical or mechanical means are available and usage of which are consistent with state and federal law. If available mechanical or medical means are not sufficient for management of the patient, the patient shall be transferred to another institution that can provide appropriate care.

9. The attending Practitioner is required to document the need for continued hospitalization after special periods of stay as identified by the Quality Improvement Committee of the Hospital in consultation with the Medical Executive Committee. This documentation must contain:

   (a) an adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;

   (b) the estimated period of time the patient will need to remain in the Hospital; and

   (c) plans for post-hospital care.

10. Patients shall be discharged only on a written or verbal order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

11. In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. Policies with respect to pronouncement of death and release of dead bodies shall conform to local law and Hospital policy.

    Under Wisconsin law, only a physician (or in limited circumstances, the coroner or medical examiner) is authorized to sign a death certificate.

    The body may be transported to the morgue without the physician's physical presence at the bedside under the following circumstances:

   (a) if death has been expected and there is a progress note to that effect present in the chart;

   (b) if the physician is immediately notified of the lack of blood pressure, pulse and respiration by the nurse in charge; or

   (c) if the physician orders discontinuation of therapy and orders the body to be transferred to the morgue (the physician subsequently must make appropriate entries into the progress notes of the patient's chart).

12. It shall be the duty of staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a proper consent, signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist or his/her designee. Provisional anatomic diagnosis shall be recorded on the medical record within 48 hours, and the complete protocol should be made a part of the record within three months.

B: MEDICAL RECORDS

1. The attending Practitioner is responsible for the preparation of a timely, accurate, complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include (1) identification data; (2) a typewritten history and physical examination including, at a minimum, a) the reason for admission, b) history including present illness, past history, allergies, medications, and pertinent psychosocial history, with family history and review of systems, including positive and negative results, c) physical examination including vitals,

general, HEENT, heart, lungs, and abdomen, with pelvic/rectal, musculoskeletal, and neurologic exams, as indicated by diagnosis, d) plan of care, e) provisional diagnosis, and f) treatment; (3) consultations, (4)-progress notes, (5) operative report, if appropriate; (6) final diagnosis; and (7) discharge summary, if required. Documentation must support services rendered, substantiate severity of illness and justify admission of the patient to the Hospital. The other components of a complete medical record, including laboratory, radiology and other diagnostic orders and reports, anatomical gift information, and autopsy reports, are the responsibility of the appropriate department, service, or Practitioner.

2. A complete admission history and physical examination shall be completed and documented in the patient's medical record within 24 hours of admission by someone who has been authorized/privileged by the organization. When a patient is readmitted within 30 days for the same or a related condition, an interval note may reference the previous history, and the patient's medical record will be updated to document an examination for any changes in physical findings. The updated examination must be completed and recorded in the patient's medical record by a member of the Medical Staff (within no more than 24 hours of admission).

3. In order to use a History and Physical document from another organization, a Licensed Independent Practitioner (LIP) or other individual who has been authorized and privileged by our organization will need to:

   (a) Review the history and physical examination document;

   (b) Conduct a second assessment to confirm the information and findings;

   (c) Update any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period) and the current physical/psychosocial status; and

   (d) Sign and date the information as an attestation to it being current within 24 hours after admission.

4. A pre-operative evaluation will be done and documented in the patient's record within 30 days of surgery or a procedure requiring anesthesia services. If the evaluation is done more than 24 hours before surgery or a procedure requiring anesthesia services, an interim note will be entered in the record that includes documentation of an updated history and physical. When the history and physical examination are not recorded before the time stated for an operation, the procedure shall be canceled unless the attending Practitioner states in writing that such delay would constitute a substantial hazard to the patient.

5. The attending physician shall countersign the history, physical examination and preoperative note when they have been recorded by an Allied Health Professional.

6. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Patients shall be seen and progress notes shall be written by the responsible Practitioner at least daily and more frequently when warranted, such as for critically ill patients or where there is difficulty in diagnosis or management of clinical problems.

7. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery for all surgical patients and the report promptly signed by the surgeon and made a part of the patient's current medical record. Failure to do so could result in suspension of O.R. privileges if the report is not received within 24 hours.

8. Consultations shall include a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and the recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" is not acceptable. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations and the fact of emergency should be documented.

9. The current obstetrical record shall include a complete prenatal record (unless an emergency delivery), including Rh factor, complications and other pertinent information. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings, with specific reference to a heart and lung examination.

10. Appropriate laboratory work and x-ray studies shall be ordered by the Practitioner, depending upon the circumstances of each case.

11. All clinical entries in the patient's medical record shall be time-dated and authenticated with the name and the title of the person making the entry. The responsible Practitioner shall countersign clinical entries when they have been made by Medical Staff affiliates or medical preceptees. Practitioners may authenticate each other's orders, provided they accept full responsibility for the order, including the diagnosis, appropriateness of dosage and choice of medication.

12. Errors must be corrected in the acceptable format, i.e., a single line drawn through the text accompanied by the word error. The writer must sign, date, and time all corrections.

13. A Practitioner's orders must be permanently recorded (not written in pencil) and written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the person authorized to execute the order.

14. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of accepted abbreviations, and "do not use" abbreviations, as delineated in house-wide policy 1.110, is accessible on the Hospital Intranet.

15. A discharge summary shall be written or dictated within 30 days of discharge or death on all medical records of inpatients except for normal deliveries and normal newborn infants and should answer briefly the following five questions. In all instances, the content of the medical record shall be sufficient to justify the diagnoses and warrant the treatment and end result. All summaries shall be authenticated by the responsible Practitioner.

    (a) The reason for admission. (A brief clinical statement of the chief complaint and history of the present illness;

(b) The pertinent laboratory, x-ray and physical findings. (Negative findings may be as pertinent as positive ones;)

(c) Medical and/or surgical treatment, (including the patient's response, complications, consultations and the like;)

(d) The patient's condition on discharge. (Ambulation, self-care, able to work;)

(e) Instructions for continuing care. (Medication by name and dosage, physical activity and diet, other therapeutic measures, referrals and follow-up appointments;)

16. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and time-dated and signed by the responsible Practitioner upon discharge of patient. This will be deemed equally as important as the actual discharge order.

17. Written informed consent of the patient as defined by Wisconsin law and the Health Information Portability and Accountability Act ("HIPAA") is required for release of medical information to persons not otherwise authorized to receive that information.

18. Original medical records may be removed from the Hospital jurisdiction and safe keeping only in accordance with a court order, statute or with the permission of the Chief Executive Officer or his/her designee. All records are the property and responsibility of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer (or his designee). In case of readmission of the patient, all previous records shall be available for the use of the Practitioner providing care.

19. If waiver of individual patient authorization has been approved by the applicable institutional review board or a privacy board in accord with federal privacy regulations, and the researcher has made the representations required under the privacy regulations, access to medical records free of charge of all patients shall be afforded members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients, provided the release is authorized under state and federal law and the patient has not filed a written objection with the Hospital. The medical record director shall have the authority to evaluate whether the release is authorized by law and to then provide such records. If there are questions as to the volume of work or appropriateness of the study, the request may be submitted to the Medical Executive Committee for consideration. For purposes other than research, subject to the discretion of the Chief Executive Officer or his/her designee, former members of the Medical Staff shall be permitted free access to information from medical records of their patients covering all periods during which they attended such patients in the Hospital so long as the Practitioner is caring for the patient at the time of the request or has written consent of the patient.

20. A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the Practitioner.

21. Medical records must be completed within 30 days after death or discharge of the patient except in special circumstances. Failure to complete records within the allotted time may result in suspension of admitting privileges until such records are completed. Habitual record delinquency shall be sufficient grounds for permanent suspension of privileges. See Hospital-Wide Policy #1.713, Incomplete/Delinquent Medical Records.

22. When a record is incomplete because of a Practitioner's death or change of location, the record shall be completed to the extent possible based upon the information available at the time and declared complete for administrative purposes and a note attached to the record explaining the reason for filing the record incomplete.

C: ORDERS FROM INDIVIDUALS WITHOUT CLINICAL PRIVILEGES OR MEDICAL STAFF MEMBERSHIP

The Hospital may accept and execute orders for outpatients from health care professionals who are not members of the Medical Staff or the Allied Health Staff and who have not been granted any clinical privileges at the Hospital only if all of the following conditions are met:

1. The order is within the ordering professional's scope of practice as established by State law.

2. The ordering professional is currently licensed in any state in a field of practice recognized by Wisconsin law and, upon the Hospital's request, provides evidence of such current license which is satisfactory to the Hospital and the professional is not excluded from any federally-funded health care program. OIG and GSA reports will be run for each ordering professional prior to orders being executed.

3. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional.

4. The ordering professional does not hold himself or herself out to be associated or affiliated with the Hospital or its Medical Staff.

D: GENERAL CONDUCT OF CARE

1. A general consent form signed by or on behalf of every patient receiving services from the Hospital must be obtained at the time of registration. The admitting department 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 consent before the patient is treated in the Hospital. In the event of admission of incompetents and others incapable of consenting, the legal guardian, the spouse, adult child, parent or adult sibling should consent, in that order, as applicable.

2. Diagnostic and Therapeutic Orders. Therapeutic care may be given to patients only by or on the order of a Practitioner who has been granted clinical privileges. Written orders or diagnostic testing may be accepted from health care professionals without clinical privileges who meet the criteria set forth in Rule C. Orders shall be specific and complete. Hospital personnel shall not attempt to carry out improper or illegibly written orders but shall promptly obtain such orders in proper or legible form. The use of "review", "repeat", and "continue" orders is not acceptable.

3. Verbal or Telephone Orders. Verbal orders may be given by a Practitioner who has been granted clinical privileges to an approved health professional. Telephone orders are those given by a Practitioner or other authorized health care professional who has been granted clinical privileges to an approved health professional by telephone. Verbal or telephone orders require a verification "read-back" of the complete order by the person receiving the order. All verbal and

telephone orders shall be authenticated (signed and time-dated) no later than 48 hours after entry by the Practitioner responsible for ordering, providing or evaluating the service. Verbal and telephone orders shall be strictly confined to circumstances in which patient care needs require them.

4. Medication orders may be taken only by a registered nurse, pharmacist, or medical student functioning within his/her sphere of competence. Other licensed health professionals may take verbal or telephone orders pertaining directly to their profession. Non-medication verbal or telephone orders may be dictated to a Unit Secretary functioning within his/her sphere of competence and shall be countersigned by an R.N. according to the Department of Nursing Policy.

5. Verbal or telephone orders shall be promptly transcribed and signed in the medical record. The entry shall include the date, time, signature of the individual taking the order, and the name of the Practitioner. The order shall be countersigned by the prescribing Practitioner or the attending physician within 48 hours, if the order was given by the on-call physician.

6. Telephone orders for diagnostic tests may not be accepted from health care professionals without clinical privileges.

7. All previous orders are canceled when patients go to surgery.

8. All drugs and medications administered to the patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary or American Hospital Formulary Service. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the use of investigational drugs in hospitals and all regulations of the Food and Drug Administration. The automatic stop orders of 72 hours will be maintained on those drugs considered to be "dangerous" (see specific listing). The automatic stop order applies when the order does not specify this. The Pharmacy and Therapeutics Committee shall review automatic stop policies at least yearly.

9. An order for a radiology examination shall contain a concise statement of the reason for the examination, along with the name and title of the ordering Practitioner.

10. Any qualified Practitioner or Allied Health Professional with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

11. The attending Practitioner is primarily responsible for requesting consultation when indicated or for calling in a qualified consultant. Except in an emergency, permission of the patient or the patient's representative shall be obtained and the request for consultation shall be documented in the medical record.

12. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the Practitioner responsible for the care of the patient. It is the duty of the Hospital staff through its Service Chairpersons and the Medical Executive Committee to see that members of the staff do not fail in the matter of calling consultations as needed. Except in an emergency, consultation is required in the following situations:

    (a) when the patient is not a good risk for operation or treatment;

(b) where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) where there is doubt as to the choice of therapeutic measures to be utilized;

(d) in unusually complicated situations where specific skills of other Practitioners may be needed;

(e) when requested by the patient or the family;

(f) at Sacred Heart Hospital in instances where the patient exhibits severe psychiatric symptoms. At Saint Mary's Hospital in instances where the patient exhibits severe psychiatric symptoms and is not admitted to the Ministry Behavioral Health Inpatient Unit.

13. Patients have a right to be free from restraints that are not medically necessary. The attending Practitioner responsible for the care of the patient must provide an order for restraint and seclusion protocol initiation by Hospital personnel and the order may not be made on a standing or on an as needed (PRN) basis. The attending Practitioner must be consulted as soon as possible if restraint or seclusion is ordered by a patient's attending Practitioner. If restraint or seclusion is for behavior management, a Practitioner must conduct a face-to-face evaluation of the patient within one hour after initiation of the seclusion or restraint. Orders for such restraints are limited to four hours for adults, two hours for children ages 9-17, and one hour for children under age 9, but may be renewed for similar time periods for up to 24 hours, at which time the Practitioner must again see and assess the patient before issuing a new order to continue the restraint. A new order for continuation of such restraint if desired may be written after 24 hours. Any order for restraint or seclusion shall be documented in the patient's medical record and shall note the alternative or less restrictive interventions attempted (as applicable), the patient's conditions or symptoms that warranted the use of restraint or seclusion, the patient's response to the intervention used (including the rationale for continued use of the intervention), and the results of any one-hour, face-to-face medical and behavioral evaluation(s).

14. If a Hospital employee or Allied Health Professional has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the matter should be brought to the attention of the attending Practitioner(s). Following this, if there are still questions in his/her mind, he/she may discuss this with his/her supervisor. If warranted, the supervisor may bring the matter to the attention of the Chairman of the Service wherein the Practitioner has clinical privileges and the Chairman may take appropriate action including himself/herself requesting a consultation. If the Service Chairman is unavailable or the supervisor feels further action is required, he/she will contact the Medical Staff President.

15. Critical test results may be communicated to the ordering or attending Practitioner by telephone, and the receiving Practitioner must repeat back the test results to verify transmission of the correct results.

E: GENERAL RULES REGARDING SURGICAL CARE

1. Surgeons must be in the operating room ready to commence operation 30 minutes prior to the scheduled incision time.

2. Prior to anesthesia and the surgical procedure, the patient's records shall contain a history and physical examination, appropriate laboratory test results, appropriate radiology test results, provisional diagnosis and appropriate consultation prior to the operation except in emergencies. The pre-anesthesia note shall be completed or countersigned by the operating surgeon or anesthetist with findings (including anesthesia risk, anesthesia drug and allergy history, potential anesthesia problems identified and patient condition prior to induction of anesthesia) recorded and time-dated within 48 hours before surgery. In any emergency, the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. Every patient also shall have a post-anesthesia follow-up examination completed or countersigned by an individual qualified to administer anesthesia with findings (including vital signs, level of consciousness, sensation if epidural, intrathecal or spinal and any complications) recorded and time-dated within 48 hours after surgery.

3. To assure proper identification of the patient, the Hospital staff member placing the identification band on the patient will ask the patient to state their name and date of birth, verifying the information on the patient's hospital identification band prior to placing the band. Specimens must be labeled at the bedside with the name, account number, date/time collected, source, tests requested, and the initials of the person collecting it.

4. An Informed Consent form should be signed by the patient, legal custodian, or guardian except in cases of emergency.

   Written, signed, informed surgical consents are required prior to the operative procedure except in those situations wherein the patient's condition constitutes a substantial and immediate threat to his/her life or health. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent, specifically worded, should be obtained. If two or more specified procedures are to be carried out at the same time and this is known in advance, they may be all described and consented to on the same form.

5. Pregnancy testing should be performed on patients receiving hysterectomies or curettage if the possibility of pregnancy exists.

6. All operations performed shall be fully described by the operating room surgeon.

7. The Practitioner performing the procedure with the patient involved will mark the correct site(s) using an indelible marker visible within the surgical/procedural field. When the patient is a minor child or an individual unable to speak for themselves, verification will be performed with the legally responsible party. For a surgical patient the marking is completed prior to the patient's arrival in the OR. The marking will be the word "yes" and the Practitioners initials and will be documented per protocol. An "X" is not acceptable. Documentation and verbal

identification must agree in procedure and site/side prior to the start of the surgery / procedure. Refer to Hospital Wide Policy and Procedure 1.618 Correct Surgical / Procedural Identification.

For surgery patients, the patient will remain in the ambulatory/PACU area until confirmation is assured.

a) The RN will document the patient's name, date of birth, patient position, special equipment needs and procedure to be performed in the operating room on the count board

b) Prior to the incision the surgeon will perform a "time out" to verify the following with the perioperative team
   - Correct patient identity
   - Operative site(s)
   - Procedure to be performed
   - Correct patient position
   - Antibiotic given, if applicable
   - Availability of any implants and/or special equipment

c) It is the circulators' responsibility to present the operative consent for site confirmation with all involved surgical team members (anesthesia provider, MD, surgical technician, RN and surgical assistant)

d) After verification by all team members, the circulator will complete the "Operative Site Verification" section on the Procedure Site Confirmation form or Surgical Site Confirmation Form.

8. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation up to 2-3 weeks before surgery for planned surgeries, re-evaluation on the day of surgery, and postanesthetic follow-up of the patient's condition within 48 hours of surgery. All findings must be recorded, time-dated and signed within 48 hours of the evaluation.

   (a) Preanesthetic evaluation and postanesthetic follow-up documentation entered into the record by an anesthetist must be countersigned by an anesthesiologist or in his absence by the attending Practitioner.

9. Appropriate tissues removed at operation shall be sent to the Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated reports shall be made a part of the patient's medical record.

10. Surgical dental care is a dual responsibility involving the dentist and physician_member of the Medical Staff.

   (a) Dentist's responsibilities:

      (1) a detailed dental history justifying Hospital treatment;

(2) a detailed description of the examination of the oral cavity, associated structures and a preoperative diagnosis;

(3) a complete operative report, describing the findings and techniques. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

(4) progress notes pertinent to the oral condition;

(5) discharge summary;

(6) instructions regarding dental care when the patient is discharged.

11. Surgical podiatric care is a dual responsibility involving the podiatrist and physician member of the Medical Staff.

(a) Podiatrist's responsibilities:

(1) a detailed podiatric history justifying Hospital treatment;

(2) a detailed description of the podiatric examination and a preoperative diagnosis;

(3) a complete operative report, describing the findings and techniques;

(4) progress notes pertinent to the podiatric condition;

(5) discharge summary;

(6) instructions regarding podiatric care when the patient is discharged.

12. Physician's responsibility for dental and podiatric admissions.

(a) Medical history pertinent to the patient's general health.

(1) A physical examination to determine the patient's condition, including an appropriate review of systems, including vital signs and an evaluation of overall medical risk, prior to anesthesia and surgery.

(2) Supervision of the patient's general health status while hospitalized.

13. Assistants in Surgery.

(a) In any surgical procedure with significant hazard to life, there must be a qualified assistant present and scrubbed.

(b) In any surgical procedure with unusual hazard to life, in the opinion of the operating surgeon, the assistant should be a staff physician if available.

14. The Department of Surgery is responsible for the overall management of the Ambulatory Care Services of the Hospital.

(a) A comprehensive history and physical examination is required on Ambulatory Care Patients. The minimum content of an outpatient history and physical examination is the same as for inpatient H&P's as outlined in Section B1.

(b) Elective outpatient surgery patients may be admitted the morning of the outpatient procedure upon discretion of the admitting Practitioner.

(c) Outpatients having surgical procedures are to have laboratory work as determined by the attending Practitioner and/or anesthesiologist.

F: GENERAL RULES REGARDING OBSTETRICAL CARE

1. The obstetrical record shall include a complete prenatal record, including Rh factor, complications and other pertinent information. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval note must be written that includes complications, pertinent additions to the history, and any subsequent changes in the physical findings.

2. Except in emergency, consultation with another qualified physician shall be required in all curettages or other procedures by which a known or suspected intrauterine pregnancy may be interrupted.

3. For use of oxytocics, ~~P~~please refer to the current Policies and Procedures of the Obstetric Department.

G: EMERGENCY/URGENT CARE SERVICES

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency/urgent care services area. This shall be in accord with the Hospital's basic plan for delivery of such services. The Medical Staff has determined that physicians who have been appointed to the (2) Provisional /Active Staff of Sacred Heart-Saint Mary's Hospitals, Inc. and meet the "Criteria for Granting Privileges in the Emergency Department/Urgent Care Center" are qualified to cover the Emergency Department/Urgent Care Center in the Hospitals.

2. The duties and responsibilities of all personnel serving patients within the emergency/urgent care area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multi-specialty committee of the Medical Staff, including representatives from nursing service and Hospital administration. It shall be approved by the Medical Staff and by the Governing Body.

3. An appropriate medical record shall be kept for every patient receiving emergency/urgent care service and be incorporated in the patient's Hospital record, if such exists. The record shall include:

   (a) adequate patient identification;

   (b) information concerning the time of the patient's arrival, means of arrival, and by whom transported;

(c) appropriate time notations, including time of physician notification, time of treatments, including administration of medications, and time of patient discharge or transfer from the service;

(d) pertinent history of the injury or illness, including details relative to first aid or emergency/urgent care given the patient prior to his/her arrival at the Hospital;

(e) physical findings;

(f) description of significant clinical, laboratory, and roentgenologic findings;

(g) final diagnosis, without use of abbreviations;

(h) treatment given, including time of treatment and of administration of medications;

(i) condition of the patient on discharge or transfer;

(j) final disposition, including time of discharge and instructions given to the patient and/or his/her family relative to necessary follow-up.

4. Each patient's medical record shall be signed by the Practitioner in attendance, who is responsible for its clinical accuracy.

5. The review of Emergency Department/Urgent Care Center services shall be a function of the Emergency Room Committee.

6. Procedures that may be performed in the Emergency Department/Urgent Care Center and cases that should be transferred elsewhere are to be followed as outlined in the Emergency Department/Urgent Care Center Policy and Procedure Manual as approved by the Medical Staff and Hospital Administration.

7. Whenever a patient with an emergency/urgent care medical condition or a patient in active labor is transferred to another facility not operated under the Hospital's provider number and not located on the Hospital's main campus, after the Hospital's legal obligation to provide stabilizing treatment as is within the Hospital's capacity has been met, or after the responsible physician determines the medical benefits of transfer outweigh the risks of transfer, there must be positive acceptance by the receiving facility or physician, and all pertinent medical information, including a Transfer Consent, should accompany the patient. The patient's medical record shall reflect compliance with these requirements.

8. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The Disaster Plan is coordinated through the Safety Team. Disaster drills will be rehearsed at least twice yearly. A critique of such drills shall be provided to the Medical Executive Committee. A copy of the plan shall be on file in the emergency area.

9. The scope of privileges granted to Courtesy staff Emergency Department physicians is as follows unless otherwise specified by the Credentials Committee.

(a) **Emergency Department Patients**: All patients presenting themselves at the Emergency Department/Urgent Care Center, except those specifically treated by their private physician, are to be evaluated, and treated by the Emergency Department/Urgent Care Center physician.

(b) **Admissions**: On any admission from the Emergency Department/Urgent Care Center, there must be a consultation between the Emergency Department/Urgent Care Center physician and the Medical Staff member to whom the patient is being admitted (the patient's private physician or the back-up physician). The Emergency Department/Urgent Care Center physician may write the initial admitting orders in consultation with the Medical Staff member to whom the patient is being admitted. On the inpatient record, the private physician is responsible for the history and physical. A brief holding note is recommended.

(c) **Transfers**: Any transfer from the Emergency Department to another health care facility shall be in compliance with COBRA and Emergency Department policies.

(d) **Referrals and Follow-up**: All patients released from the Emergency Department/Urgent Care Center will be referred to their private physician, or, if they have no private physician, the back-up physician for follow-up care. Every patient should leave the Emergency Department/Urgent Care Center with an instruction sheet signed by the patient and the emergency department registered nurse.

(e) **Inpatients**: The Emergency Department physician should respond to inpatient emergency situations. Since the Emergency Department physician may be called to manage in-house emergencies, he/she should be aware of any critically ill patients in the Hospital. The Emergency Department physician will pronounce deaths at the attending physician's request. (The attending physician is responsible for filling out and signing the death certificate).

(f) **Emergency Department/Urgent Care Center Records**: All charts must be complete with appropriate information, time, date and signatures.