NATIONWIDE CHILDREN'S HOSPITAL TOLEDO

MEDICAL STAFF

CLINICAL CARE POLICY

Revised: August 2024

TABLE OF CONTENTS

The definitions set forth in the Medical Staff Bylaws (and Advanced Practice Provider Policy with respect to Advance Practice Providers shall apply to this Clinical Care Policy ("Policy") unless otherwise provided herein.

I. Admission and Discharge of Patients

A. The Hospital shall accept patients for care and treatment within its clinical capabilities and the services offered.

B. Patients may be admitted to the Hospital only by:

1. Members of the Medical Staff with admitting Privileges;

2. Advanced Practice Providers ("APPs" or "APP") with admitting Privileges in accordance with applicable laws, rules/regulations, and Hospital and Medical Staff policies provided the admission order is dated, timed, and countersigned prior to the patient's discharge by the Practitioner with admitting Privileges under whose name the patient is admitted; or

3. House Staff in accordance with applicable laws, rules/regulations, Hospital and Medical Staff policies, and their GME Program provided the admission order is countersigned, dated, and timed prior to the patient's discharge by the resident's supervising attending Physician who has admitting Privileges.

C. The responsible attending Practitioner will be identified on the admission order.

D. The attending Practitioner is required to document (certify) the need for continued hospitalization at intervals consistent with quality standards of care, but not less frequently than those intervals specified by third party payers.

E. Patients shall be discharged by order of the responsible attending Practitioner, or other authorized Practitioner, House Staff, or an APP caring for the patient, in accordance with applicable laws, rules/regulations, and Hospital and Medical Staff policies. If the discharge order is completed by House Staff, the resident's supervising attending Physician must date, time and countersign the discharge order.

F. A notation shall be made in the electronic medical record (EMR) if a patient leaves the Hospital against the advice of the attending Practitioner or without proper discharge.

II. Medical History and Physical Examination

A. A medical history and physical examination (H&P) (and update thereto, when required) shall be completed and documented in accordance with the requirements set forth in the Medical Staff Bylaws and Credentials Policy.

B. For outpatients receiving surgery, or a procedure requiring moderate sedation/anesthesia services, the attending anesthesiologist or procedural sedationist may perform the H&P (or update thereto, as applicable) which shall include, at a minimum, documentation of a heart, lungs, and airway examination.

C. In the event of an emergency necessitating surgery or a procedure requiring anesthesia services, the responsible Practitioner must, if possible, document the nature of the emergency and record a progress or admission note describing a brief

history, physical findings, and the preoperative diagnosis in the EMR before surgery or the procedure. A complete H&P must be documented as soon as possible after the emergency surgery or procedure but in no event later than 24 hours after the emergent situation.

D. The content of the H&P shall be medically appropriate for each patient's presenting problem(s) as determined by the clinical judgment of the Practitioner or APP granted Privileges at the Hospital to complete and document the H&P (or update thereto, as applicable).

1. The H&P shall include, at minimum, all of the following:
   i. chief complaint;
   ii. history of present illness/condition;
   iii. physical examination relevant to the patient's presenting illness/condition [to include, as applicable: vital signs, height/weight, head circumference, developmental assessment, and documentation of ears, eyes, nose, throat, skin, neck, lungs, heart, neurologic, genitalia (for all infants and when clinically indicated in older children/adolescents), abdomen, and extremities]
   iv. information regarding the patient's medications and any allergies;
   v. assessment/impression; and
   vi. plan of care

2. The H&P may also include, as medically appropriate: The patient's past medical history, past surgical history, family medical history, and/or social/developmental history; education/social status; review of immunization records; review of pertinent laboratory, radiologic, and other diagnostic results; family/caregiver legal status; family/caregiver expectation of/involvement in care.

E. H&Ps (or updates thereto, as applicable) completed and documented at the Hospital by House Staff must be countersigned, dated, and timed by the supervising attending Physician and otherwise addressed in such manner as required by applicable laws, rules, and/or regulations.

F. H&Ps (or updates thereto, as applicable) completed and documented at the Hospital by APPs granted Privileges to do so must be countersigned, dated, and timed by the responsible attending Practitioner.

III. <u>Consultations</u>

A. Practitioners granted Privileges at the Hospital are required, as an obligation of Medical Staff appointment and Privileges, to provide patient consultations upon request. Any qualified Practitioner may consult with respect to patient care provided he/she has Privileges appropriate to the patient's condition.

B. An APP may request a consultation from his/her collaborating or supervising Practitioner or from another qualified Practitioner with appropriate Privileges at the Hospital as needed. An APP may provide a consultation, upon request, within his/her scope of practice, consistent with the Privileges granted to such APP, and in accordance with/subject to applicable laws, rules, and/or regulations.

C. When possible, consultations shall be arranged through communication between the attending Practitioner/requesting APP and the consulting Practitioner/APP.

D. A consultation note/report will include the date/time of the consultation, findings of the consultant's examination/evaluation of the patient and review of the patient's medical record, and the consultant's recommendation and/or opinion. The consultation note/report should be signed, dated, and timed within 24 hours after consultant notification or sooner if necessitated by the condition of the patient.

E. Consultations performed and documented by House Staff must be countersigned, dated, and timed by the supervising attending Physician, who shall also assess the patient, within 24 hours after consultant notification or sooner if necessitated by the condition of the patient.

F. Consultations performed and documented by APPs granted Privileges to do so must be countersigned, dated, and timed by the responsible Practitioner with the exception of delivery attendance consultations performed and documented by neonatal nurse practitioners.

IV. Orders

A. All orders, including verbal/telephone orders, shall be dated, timed, and signed promptly by the Practitioner or APP that issued the order or by another authorized Practitioner who is responsible for the care of the patient, only if such individual is acting in accordance with state laws/regulations, Hospital policies, and the Medical Staff governing documents.

B. Verbal orders from Practitioners or APPs who are physically present in the Hospital are discouraged except in emergency situations. Verbal/telephone orders shall be used infrequently and only when necessary (*e.g.,* in those situations where it is impossible or impractical for the ordering Practitioner or APP to write or electronically enter the order.

1. Verbal/telephone orders may be received, recorded, and carried out by qualified healthcare personnel authorized by the Hospital to do so consistent with applicable laws, rules, and/or regulations.
2. All verbal/telephone orders shall be signed by the authorized person to whom the order is dictated. The recipient's name, the name of the Practitioner or APP who issued the order, and the date and time of the order shall be noted.
3. The authorized recipient shall document or enter the verbal/telephone order in the patient's EMR, read the order back to the Practitioner or APP who issued the order, and indicate that the issuing provider has confirmed the order.
4. The Practitioner or APP who issued the verbal/telephone order or another authorized Practitioner who is responsible for the care of the patient shall promptly date, time, and sign the verbal/telephone order as soon as possible, such as during the next patient visit, but in no case longer than 72 hours after issuing the verbal/telephone order.

C. Restraints are initiated and evaluated according to applicable Hospital policy.

V. Discharge Summary

A. All patient medical records must contain a discharge summary, completed using the applicable form in the EMR, or a final progress note as permitted by subsection D.

B. The discharge summary contains: a statement of the reason for hospitalization; a summary of the patient's hospital course (*i.e.,* the care, treatment, and services provided); final diagnosis; operations and procedures performed (if any); complications; review of discharge medications; the patient's condition/prognosis/disposition at discharge; information/instructions given to the patient/family; and provisions for follow-up care.

C. The discharge summary must be signed, dated, and timed by the Practitioner or APP who wrote the summary. If the discharge summary is completed by someone other than the responsible attending Practitioner, then the responsible attending Practitioner must date, time, and countersign the discharge summary within 30 days following the patient's discharge.

D. A discharge summary is not required when an outpatient is in a bed. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

VI. Electronic Medical Record

A. An accurate medical record shall be maintained for every patient receiving care, treatment, and/or services.

B. EMR entries must have an electronic signature.

C. Use of signature stamps or rubber stamps is prohibited.

VII. Medical Students

A. In certain instances, an attending Practitioner and House Staff may utilize a medical student's documentation of certain components of medical services in the electronic medical record without the need for the attending Practitioner or House Staff to redocument such components. Medical students may perform and document the following only for History and Physicals ("H&Ps"), daily inpatient progress notes, or ambulatory clinic notes and only if the attending Practitioner or House Staff are in the exam room with the medical student and patient while the medical student is performing the medical service ("Physically Present"):

(1) History of Present Illness ("HPI").

(2) Physical Examination ("PE")

(3) Assessment/Plan/Medical Decision Making ("MDM").

B. If a medical student performs and documents an HPI, PE, or MDM, for daily inpatient progress notes or ambulatory clinic notes, then the attending Practitioner or House Staff (as applicable) who is Physically Present must perform or re-perform the PE or MDM, as applicable; and, to the extent the attending Practitioner or House Staff who is

Physically Present desire to utilize the medical student's documentation in the electronic medical record, review, verify, and agree with the medical student's documentation or amend such documentation as appropriate.

C. If a medical student performs and documents an HPI, PE, or MDM for an H&P, then the attending Practitioner who is Physically Present (or the House Staff who is Physically Present so long as they are qualified and permitted to perform and document an H&P) must perform or reperform each component of the H&P, including the HPI; and, to the extent the attending Practitioner who is Physically Present desires to utilize the medical student's documentation in the electronic medical record, then the attending Practitioner (or House Staff as applicable) must review, verify, and agree with the medical student's documentation or amend such documentation as appropriate.

D. Any medical student documentation utilized and entered into a patient's electronic medical record, must be appropriately attributed to such medical student and must be counter-signed by the attending Practitioner.

E. Attending Practitioners and House Staff may not utilize a medical student's documentation in the medical record as described in paragraph (A) above for consult notes, procedure notes, discharge summaries, or death summaries.

F. Any medical student documentation within the electronic medical record must be appropriately attributed to the medical student.

VIII. Operative and Invasive Procedures

A. A timeout will occur prior to surgical incision or start of the procedure.

B. All previous orders written for the patient are not effective while the patient is in the operating/procedure room but may be resumed post operatively/post procedure consistent with the applicable process set forth in the Patient Care Medication Ordering Policy.

C. When the full operative or procedure report is not immediately available, a(n) procedure or operative note must be entered immediately after an operation or other invasive procedure and before the patient is transferred to the next level of care. The procedure or operative note must contain the:

1. procedure performed;
2. Practitioner performing the surgery or procedure and assistants;
3. specimens removed;
4. complications;
5. description of procedural findings;
6. estimated blood loss; and
7. post-operative diagnosis

D. The full operative or procedure report must be documented in the medical record within three (3) days after completion of the surgery/procedure. The operative/procedure report must include the:

1. name and Hospital identification number of the patient;
2. date and time of the surgery/procedure;
3. preoperative and postoperative diagnoses;
4. name of the surgery/procedure performed;
5. type of anesthesia administered;

6. a description of the procedure/techniques;
7. findings of the procedure;
8. estimated blood loss;
9. specimen(s)/tissues removed or altered;
10. complications, if any;
11. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any;
12. the name(s) of the primary surgeon(s) or Practitioner(s) who performed the operation/procedure and assistant(s) who performed surgical tasks (even when performing those tasks under supervision); and
13. a description of significant surgical tasks that were conducted by Practitioners/APPs other than the primary surgeon/Practitioner who performed the operation/procedure. Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.

E. All tissue specimens removed during a procedure shall be sent to the Mercy St. Vincent Pathology Department according to Hospital policy.

IX. Medication

A. See Patient Care Medication Ordering Policy.

X. House Staff

A. References in this Policy to "House Staff" shall mean medical residents who are given patient care responsibilities (under the supervision of a supervising/teaching attending Physician) commensurate with the resident's level of training, experience, and capability; as permitted by and consistent with the scope of each such resident's current responsibilities within the residency training program; subject to applicable laws, rules, and regulations; and, as otherwise detailed in training policies, procedures, protocols, and educational agreements coordinated by the applicable training program director in accordance with the Accreditation Council for Graduate Medical Education.

ADOPTION & APPROVAL

Adopted by the Medical Executive Committee on August 28, 2024

Approved by the Hospital Board on [August 30, 2024