NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

MEDICAL STAFF
Clinical Care Policy

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The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Clinical Care Policy unless otherwise provided herein.

1.1 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. APPs with admitting Privileges in accordance with applicable laws and Hospital and Medical Staff Policies; and

3. House Staff, in accordance with applicable laws, Hospital and Medical Staff Policies, and their GME Program and only if the admission order is co-signed by their supervising attending Practitioner.

At the time of admission, the responsible attending Practitioner will be identified on the admission order.

C. Except in an emergency situation, no patient shall be admitted to the Hospital until after a provisional diagnosis has been recorded. In the case of an emergency a provisional diagnosis shall be recorded as soon as possible

D. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the admitting Practitioner, APP, or House Staff, as applicable, shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

E. Patients admitted through the Emergency Department will be asked if they have a personal primary Practitioner. In such cases, it is the responsibility of the Emergency Department staff to (1) update the patient's personal primary Practitioner's information in the electronic medical record and (2) contact the patient's personal primary Practitioner to inform such personal primary Practitioner that their patient has been admitted to the Hospital.

F. No patient shall be assigned to the care of a Practitioner without the consent of that Practitioner or his/her designee.

G. All patients not requesting a specific Practitioner or not having been referred to a specific consultant by their personal primary Practitioner shall be attended by a Practitioner with the appropriate Clinical Privileges, as assigned by the appropriate Department Chief or Section Chief, indicated in the treatment of the disease which necessitated admission. Names of

Practitioners so assigned shall be furnished to the Admitting Department by the applicable Department Chief or Section Chief. The service to which a patient shall be assigned should be indicated by the admitting Practitioner.

H. The admitting Practitioner, APP, or House Staff, as applicable, shall be held responsible for giving such information as may be necessary to assure the protection of others (*e.g.,* other patients, staff, visitors).

I. The attending Practitioner is required to document (certify) the need for continued hospitalization at intervals consistent with quality standards of care, but not less frequent than those intervals specified by applicable governmental regulations and third-party payers.

J. Patients shall be discharged by order of the responsible attending Practitioner, his/her House Staff representative, or an APP.

K. Should a patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, the patient or his/her legal guardian, as applicable, shall be requested to sign a Hospital *Removal Against Medical Advice* form. A notation shall also be made on the patient's record.

L. Patients with infectious diseases will be assigned rooms and isolated according to Hospital policy.

M. A patient will be moved to the Isolation Unit if recommended by written order of the attending Practitioner or the Chief of Epidemiology.

N. Other requirements with respect to admission, discharge, and transfer of patients are set forth in Patient/Family Care Policy Number 5:01 (Admission/Discharge and Patient Placement), Patient/Family Care Policy Number 5:03 (Admission/Discharge/Transfer Guidelines for Neonatal Services), Patient/Family Care Policy Number 5:50 (Transport of Inpatients to and From Nationwide Children's Hospital), and Hospital Inpatient Psychiatry Unit Protocol Number IPP-1 (Inpatient Psychiatry Admissions, Patient Placement, Continued Stay and Discharge), as such policies may be amended from time to time.

1.2 Care of Patients

A. Patients shall be treated by Practitioners and APPs (as applicable) who have been granted Clinical Privileges (in accordance with the Medical Staff governing documents) to provide clinical care, treatment, and/or services at the Hospital.

B. Practitioners and APPs may be assisted in providing patient care, treatment, and/or services by House Staff/Postgraduate Staff and/or other qualified healthcare providers authorized by the Hospital.

1.3 Medical History and Physical Examination

A. General Requirements

1. General requirements with respect to completion and documentation of a medical history and physical examination (H&P) and H&P updates are set forth in the Medical Staff Bylaws.

2. For outpatients receiving surgery or a procedure requiring anesthesia services, the attending anesthesiologist may perform the H&P which shall include, at a minimum, documentation of a heart, lungs, and airway examination, in accordance with the Perioperative Services Policy titled History & Physical Exams for Ambulatory Patients, as amended from time to time. Outpatients receiving general anesthesia for imaging studies will be discharged from the PACU to home by the attending anesthesiologist. Patients undergoing an outpatient interventional radiological procedure will be discharged by the attending radiologist.

3. When a completed H&P is not available from the attending surgeon or other Practitioner for inpatients receiving surgery or a procedure requiring anesthesia services, the anesthesiologist may perform the H&P in addition to the pre-anesthesia evaluation and shall complete the *Anesthesia History and Assessment* form accordingly. Regardless of who completes the H&P, the attending surgeon must still examine the patient and document that the need for surgery is still present.

4. In the event of an emergency situation necessitating surgery or a procedure requiring anesthesia services, the responsible Practitioner must, if possible, document the emergency and record a progress or admission note describing a brief history, appropriate physical findings, and the preoperative diagnosis in the medical record before surgery or a procedure requiring anesthesia services. The H&P must be completed as soon as possible after the emergency surgery or procedure but, in no event, later than twenty-four (24) hours after the emergency situation.

5. With the exception of emergency situations, when the H&P is not completed and documented in the patient's medical record before surgery or a procedure requiring anesthesia services, the operation or procedure will not proceed. In the event a surgery or procedure is canceled, the reason shall be clearly noted in the progress notes.

B. Content of the History and Physical

1. The Medical Staff shall monitor the quality of H&Ps. H&P content may vary by setting or level of care, treatment, and services but both inpatient and outpatient H&Ps should, at a minimum, include the following:

(a) Medical History. The medical history shall include the following elements as medically appropriate:

(1) Chief complaint;

(2) History of present illness including, when appropriate in the clinical judgment of the responsible Practitioner, assessment of the patient's emotional, behavioral, and social history;

(3) Relevant (in the clinical judgment of the responsible Practitioner) past medical/surgical history and family history;

(4) Review of immunization records;

(5) Menstrual and obstetric history for females;

(6) Drug sensitivities/allergies;

(7) Current medications;

(8) Pertinent (in the clinical judgment of the responsible Practitioner), laboratory, radiologic, and other diagnostic results;

(9) Additional criteria for pediatric patients: head circumference (physical) for infants/children; developmental assessment (physical); education/social status and needs (history); patient and family expectation of care/outcome (history); family and caregiver legal status (history); and,

(10) Additional criteria for incompetent patients: family and caregiver legal status, expectations for and involvement in the assessment, treatment, and/or continuous care of an incompetent patient.

(b) Physical Examination. Except as otherwise noted in Section 1.3 (A)(2), the physical examination shall include the following elements as medically appropriate:

(1) Vital signs;

(2) Height and weight; and,

(3) Documentation of exam of ears, eyes, nose, throat, skin, neck, lungs, heart, neurologic, genitalia, abdomen, and extremities.

C. Dentists, Podiatrists, and Psychologists are responsible for completing and documenting the part of their patient's H&P that relates to their respective specialty consistent with the applicable sections of the Medical Staff Bylaws.

D. APPs who are granted Privileges to do so and House Staff (to the extent permitted by and in accordance with applicable laws, rules, and regulations) may complete and document a medical history and physical examination and any updates thereto.

E. H&Ps completed and documented by House Staff or an APP must be countersigned by the attending Practitioner.

1.4 Consultations

A. When a medical or surgical consult is needed, only Practitioners or APPs with appropriate Clinical Privileges or House Staff may perform consultations.

B. Routine consultations must be performed and the consultation note completed within twenty-four (24) hours after notification of a routine consultation request, or sooner if necessitated by the condition of the patient. The twenty-four (24) hour rule may be waived for routine consultations on weekends and holidays. Such elective delays require communication between the consultant and the requesting attending Practitioner, House Staff, or APP.

C. Screening consults (*e.g.,* neonatal retinal and hearing exams, rehabilitation consults for trauma victims) may be completed after twenty-four (24) hours when developmentally or medically more appropriate. These screening consults may be completed at the discretion of the consultant with appropriate notification to the patient care team.

D. Except in an emergency, consultation is required in the following situations:

1. Where specific skills of other Practitioners or APPs may be needed.

2. When requested by the patient or his/her family, as medically indicated.

E. A satisfactory consultation includes examination of the patient and the patient's medical record and completion of a recorded opinion which is made a part of the record and signed, dated, and timed by the consultant within the twenty-four (24) hour period after notification of the consultation request. The twenty-four (24) hour rule may be waived in accordance with Section 1.4 (A). When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

F. If, in the opinion of an attending Practitioner, an emergency exists wherein life, limb, or general health of a patient could be in jeopardy and the opinion of a consulting Practitioner or APP is required, direct attending Practitioner to consultant contact by phone should be established. It is expected that the consultant contacted will immediately respond or dispatch an alternate qualified Practitioner or APP.

G. The attending Practitioner is primarily responsible for requesting inpatient consultation when indicated. Except in an emergency, the attending Practitioner, or his/her designee, will provide authorization for a consult on his/her patient. An order must be completed by the requesting attending Practitioner or designee as soon as possible.

H. Consultations in the Emergency Department may be provided to patients upon request of the House Staff, an APP, or the attending staff of either the Emergency Department or the specialty services.

I. The "consult note" type should be used in the electronic medical record to document new and follow-up inpatient and Emergency Department consultations.

J. In all circumstances, consult notes entered by House Staff must be countersigned by the supervising attending Practitioner.

K. An emergency condition that warrants consultation without the attending Practitioner's (or his/her designee's) order includes any patient with a deteriorating medical condition. If the patient is in cardiorespiratory arrest outside of the intensive care units, the "Code Blue" team must be activated.

1. When appropriate, the Assessment and Consultation Team (ACT) should be activated in accordance with the Hospital's Patient/Family Care Policy Number XI-15:15 (Policy Assessment and Consultation Team (ACT)), as amended from time to time. The Physician member of ACT is permitted to consult and write orders on the patient by virtue of the team activation.

2. The ACT Physician will communicate directly to the attending Practitioner with recommendations.

(a) If the attending Practitioner agrees, ACT's recommendations are initiated.

(b) If the attending Practitioner disagrees, the attending Practitioner's plan is used and a note is left on the chart by ACT.

(c) If the attending Practitioner can't be reached, ACT's recommendations shall be implemented.

L. Consultations not referred to a specific Practitioner or APP will be referred to the person on call for the applicable Medical Staff Department/Section.

M. A consultant may defer or reject a consult request only after direct communication with the requesting Practitioner, APP, or House Staff. When a consultation is rejected, the consult request will be cancelled by the requesting Practitioner, APP, or House Staff (as applicable) and another consult ordered.

N. If a healthcare professional has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who, in turn, may refer the matter to the Chief Nursing Officer and/or Chief Medical Officer. If warranted, the Chief Nursing Officer and/or Chief Medical Officer may bring the matter to the attention of the chief of the Department or Section wherein the Practitioner caring for the patient has Clinical Privileges. Where circumstances justify such action, the chief of the Department or Section may request a consultation.

1.5 Removal of Minor Patient

A. Minor patients may not be removed from the Hospital premises, except in an emergency, without the approval of the patient's legal guardian and an attending Practitioner, or his/her designee.

1.6 Procedural Guidelines

A. Procedural guidelines relating to medical practice and concerning specific Hospital clinical departments and special care units shall be reviewed and approved by the appropriate Medical Staff committees.

1.7 Patients Available for Teaching Purposes

A. Because the Hospital is a teaching institution, all patients shall be considered available for teaching purposes except when the attending Practitioner specifically designates otherwise.

1.8 Death, Autopsy, and Organ Donation

A. Requirements with respect to a Hospital death are set forth in Hospital Patient/Family Care Policy Number 12:20 (Death: Post Mortem Care and Completing a Patient End of Life Record), as such policy may be amended from time to time.

B. The Hospital shall inform the Medical Staff (specifically the attending Practitioner) of autopsies that the Hospital intends to perform. An autopsy may be performed only with a written consent signed in accordance with state law. Except for cases appropriately referred to the coroner, all autopsies shall be performed by the Hospital pathologist or by a Practitioner delegated this responsibility.

C. Consent for organ donation of all or part of the decedent's body will be requested when a patient, who is a suitable candidate, dies while under the care of the Hospital. Requirements with respect to organ procurement are set forth in the following Hospital Patient/Family Care Policies, as such policies may be amended from time to time: (1) Number 12:15 (Death: Required Notification/Consent for Organ Donation); and (2) Number 12:12 (Tissue/Organ Donation After Circulatory Death). The *Request for Anatomical Gift* form is available on all critical care units and in the End of Life Packet.

1.9 Violent, Self-Destructive, Suicidal Patients

A. The Hospital's requirements for the care of potentially suicidal, self-destructive, or violent patients are set forth in Hospital Patient/Family Care Policy Number 20:25 (Suicidal/Self-destructive/Violent Behavior), as such policy may be amended from time to time.

1.10 Advance Directives

A. The attending Practitioner is primarily responsible for ensuring compliance with the patient's Advance Directives, when applicable, in accordance with Hospital Patient/Family Care Policy Number 20:15 (Patient Advance Directive/Self-Determination), as such policy may be amended from time to time.

1.11 Orders

A. Orders upon admission must be appropriate to the patient's condition.

B. All orders, including verbal orders, shall be dated, timed, and authenticated promptly by the ordering Practitioner, APP, House Staff, or by another authorized individual who is responsible for the care of the patient, only if such individual is acting in accordance with state laws,

Hospital policies, and the Medical Staff Bylaws, Policies, rules, and regulations.

C. Unless specifically requested by the attending Practitioner, APP, or House Staff, consultants shall not enter orders on the patient but shall record their recommendations on the consultation note in the electronic medical record.

1. Exceptions to this rule apply to orders for preoperative and post-operative medications which are entered by the attending anesthesiologists and anesthesia House Staff, pre and post procedure orders which are entered by the Practitioner performing the procedure or appropriate qualified designee, and orders given in an emergency situation.

D. Drugs/medications ordered for administration to patients should be selected, distributed, and administered in accordance with policies approved by the Pharmacy and Therapeutics Committee in addition to Patient/Family Care Policy 35:01 (Medication Administration and Documentation) and Patient/Family Care Policy 35:60 (Practitioner Medication Ordering), as such policies may be amended from time to time.

E. When pre-printed patient orders are used, the responsible Practitioner, APP, or House Staff must sign the pre-printed form prior to the order(s) being acted upon.

F. Restraints are initiated and evaluated according to Hospital Patient/Family Care Policy Number 20.40 (Use of Restraints: Nonviolent (Medical Safety) and Violent), as such policy may be amended from time to time.

G. Requirements with respect to Licensed Professional Initiated Protocols are set forth in Hospital Patient/Family Care Policy Number 000:15 (Licensed Professional Initiated Protocols), as such policy may be amended from time to time.

H. Additional requirements with respect to orders are set forth in Patient/Family Care Policy Number 75:40 (Patient Care Orders and Modes), as such policy may be amended from time to time.

1.12 Medical Records

A. All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with Hospital policies and procedures.

B. The responsible attending Practitioner shall be held accountable for the preparation of a complete medical record for each of his/her patients. This

record shall include identification data; evidence of appropriate informed consent; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, x-ray, and others; provisional diagnosis; medical or surgical treatments; pathological findings; progress notes; orders; final diagnosis; condition on discharge; final discharge summary; patient's home-going instructions regarding follow-up care; and autopsy when performed. The medical record shall contain such additional information and documentation as may be required by applicable laws, rules, regulations, and/or accreditation standards (*e.g.,* The Joint Commission).

C. When a patient is readmitted within thirty (30) days for the same or a related problem, an interval H&P reflecting any subsequent changes may be used in the medical record, provided the original information is readily available and the update to the original H&P satisfies the requirements set forth in the Medical Staff Bylaws and Section 1.3.

D. Pertinent progress notes shall be documented by attending Practitioners and/or House Staff and/or APPs (as appropriate) at least daily or as the patient's condition changes.

E. Unless a shorter timeframe is required pursuant to Hospital policies, medical records must be completed within thirty (30) days following discharge. A record shall be deemed complete at such time as all required dictations and/or written reports have been completed and dated, timed, and authenticated. The responsible attending Practitioner is required to complete medical records.

F. All clinical entries in the patient's record shall be dated, timed, signed (and their authors identified) and co-signed as required.

G. Discharge Summary

1. A discharge summary shall be composed on all patients unless otherwise provided herein.

2. The discharge summary must be completed using the standard template provided in the electronic medical record.

3. The discharge clinical summary shall contain:

(a) Statement of reasons for hospitalization;

(b) Brief summary of hospital course;

(c) Final diagnosis;

(d) Operations and special procedures;

(e) Complications;

(f) Prognosis when indicated and condition on discharge;

(g) A review of discharge medications;

(h) Disposition of patient; and,

(i) Specific instructions given to patient and family regarding further care.

4. The discharge summary must be completed, dated, timed, and authenticated within forty-eight (48) hours after patient discharge by a member of the House Staff , an APP, or the attending Practitioner. If the discharge summary is completed by someone other than the responsible attending, then the responsible attending Practitioner must date, time, and co-authenticate the discharge summary within 30 days following discharge.

5. A death summary shall be composed on all patients who expire in the Hospital. The death summary must be completed, dated, timed, and authenticated within forty-eight (48) hours after patient death by a member of the House Staff, an APP, or an attending Practitioner. If the death summary is completed by someone other than the responsible attending Practitioner then the responsible attending Practitioner must date, time, and co-authenticate the death summary within 30 days. The death summary must be completed using the standard template provided in the electronic medical record. The death summary shall contain:

(a) Statement of reasons for hospitalization;

(b) Operations and special procedures;

(c) Brief summary of hospital course;

(d) Events surrounding death;

(e) Summary of resuscitation efforts;

(f) Time of death; and,

(g) Preliminary cause of death.

H. Medical record documentation must have a hand written or electronic signature. Use of signature stamps or rubber stamps is prohibited.

I. No medical record shall be deemed complete until all deficiencies have been resolved. Incomplete medical records may be deemed complete when approved by the appropriate Department and/or Section Chief(s).

J. Practitioners and APPs shall complete medical records in a timely manner in accordance with the Medical Staff Bylaws, this Policy, and any applicable Hospital policies, as such policies may be amended from time to time, but in any event shall complete all medical records within 30 days.

1. In the event a Practitioner or APP has delinquent medical records, then, such Practitioner's or APP's Clinical Privileges shall be automatically suspended in accordance with the Medical Staff Bylaws and applicable Hospital/Medical Staff policies subject to the limited exceptions set forth in Section 6.4-2 (B) of the Medical Staff Bylaws. Notification of an automatic suspension of Clinical Privileges for delinquent medical records will be given in accordance with the applicable Hospital/Medical Staff policies.

2. In the event that a Practitioner has a delinquent operative/procedure report as set forth in Section 1.13 (Q), the Practitioner's surgical Privileges will be automatically suspended pursuant to Section 1.13 (Q).

K. Written consent of the patient, if legally authorized, or his/her legal guardian is required for release of medical information to persons not otherwise authorized to receive this information.

L. Access to medical records, including x-rays, of all patients shall be afforded to Members of the Medical Staff (and their authorized designees), APPs , and House Staff for bona fide study and/or research consistent with Hospital policies and preserving the confidentiality of personal information concerning individual patients. All such projects and authorized designees shall be approved by the chief of the appropriate Department, and approved by the Institutional Review Board.

M. Transportation of protected health information must be done in accordance with Hospital Administrative Policy XI-29 (Transport of Protected Health Information to Off-Site Locations), as such policy may be amended from time to time.

N. All medical records are the property of the Hospital and shall not otherwise be removed from Hospital property without permission of the Director of Health Information Management.

O. Written instructions given by a Practitioner or APP to a patient or his/her legal guardian, as applicable, shall be documented in the patient's chart by the appropriate health care provider.

P. For Ambulatory Patients

1. Emergency Department Records

(a) An appropriate record shall be kept of each Emergency Department visit made by a patient and shall be incorporated into that patient's electronic medical record.

(b) Each Emergency Department record should contain documentation of the following:

(1) Emergency care provided to the patient prior to arrival (if any)

(2) History, physical exam, final diagnosis, and treatment

(3) Impression and plan of care

(4) Conclusions at the termination of treatment to include final disposition, condition at discharge, and any instructions for follow-up care

(c) Documentation of emergency patient transfers to other organizations include reasons for transfer, stability of patient, acceptance by the attending Physician at the receiving organization, and responsibility during transfer.

(d) Documentation should be completed in accordance with Hospital documentation policies including Patient/Family Care Policy Number 75:80 (Outpatient Clinic, Emergency Department and Urgent Care Encounter Documentation Policy), as such policies may be amended from time to time.

2. Clinic Records

(a) An accurate medical record shall be maintained for every patient receiving ambulatory care, treatment, and/or services.

(b) For patients receiving continuing ambulatory care services, by the third visit a medical summary list must contain the following:

(1) Known significant medical diagnoses and conditions

(2) Known significant operative and invasive procedures

(3) Known adverse and allergic drug reactions

(4) Chronic medications known to be prescribed for and/or used by the patient

Q. Electronic Medical Records (EMR)

1. All Practitioners and APPs who are granted Privileges to provide patient care, treatment, and/or services at the Hospital are required to complete training sessions on the use of the Hospital's EMR and to provide appropriate documentation of successful completion of EMR training to Medical Staff Services prior to the initiation of any clinical activities.

2. All Practitioners and APPs who exercise Privileges at the Hospital are required to utilize the EMR for computerized order entry and all applicable clinical documentation.

3. Non-compliance with the requirements set forth in subsection (1) and (2) may be grounds for the initiation of formal corrective action pursuant to the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

4. Enforcement of these requirements is the joint responsibility of the Medical Staff President and the Chief Medical Officer.

R. Medical Students

1. In certain instances, a medical student's documentation of certain components of medical services may be documented 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 daily inpatient progress notes or ambulatory clinic notes and only if an attending Practitioner is "Physically Present" (as defined below):

(a) History of Present Illness ("HPI") only if an attending Practitioner is Physically Present; however, if Physical Presence is met through a Subsequent Face to Face Encounter then the medical student must present the HPI to the attending Practitioner during the Subsequent Face to Face Encounter or the attending Practitioner must reperform the HPI.

(b) Assessment/Plan/Medical Decision Making ("MDM") only if an attending Practitioner is Physically Present and the attending Practitioner performs or reperforms the MDM.

(c) Physical Examination ("PE") only if an attending Practitioner is Physically Present and the attending Practitioner performs or reperforms the PE.

2. "Physically Present" means either (1) an attending Practitioner or House Staff are in the exam room with the medical student and patient while the medical student performs the service ("Present in the Room"); or (2) if an attending Practitioner performs a subsequent same-day face to face encounter with the patient ("Subsequent Face to Face Encounter").

3. A medical student may not document in the medical record as described in (R)(1) for H&Ps, consult notes, procedure notes, discharge summaries, or death summaries.

4. An attending Practitioner must review, verify, and agree with the medical student's documentation or amend such documentation as appropriate. An attending Practitioner must sign any such documentation and attest to its accuracy and the attending Practitioner's participation.

5. Medical students may not be used as scribes during their clinical rotations.

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

1.13 Rules for Operating Room

A. Except for life-threatening or limb-threatening emergencies, surgical procedures shall be performed only with documentation of informed consent from the patient and/or his/her legal guardian, as applicable.

B. The H&P shall be completed prior to any surgery or procedure requiring anesthesia services as set forth in the Medical Staff Bylaws and Section 1.3 of this Policy. The responsible Practitioner shall document in the medical record the pre-operative diagnosis and state the intended operation prior to the beginning of the procedure.

C. If a patient undergoing outpatient surgery is admitted from the operating room, the pre-operative H&P may serve as the H&P for the admission (subject to completion and documentation of an update thereto) in accordance with the requirements set forth in the Medical Staff Bylaws and this Policy. This document will remain in the chart until discharged when it is scanned into the electronic record.

D. Surgical procedures shall be performed by a Practitioner with appropriate surgical Privileges; provided, however, that when surgical procedures

involve House Staff, the Practitioner will be present for critical portions of the procedure.

E. House Staff at the appropriate level of training may begin a surgical procedure in an emergent circumstance when delaying the start of the operation until the attending surgeon is present could result in the loss of life or limb or the permanent impairment of a bodily system under the following circumstances:

1. If the attending surgeon determines that the case is emergent and is not immediately available, the attending surgeon will directly inform the charge RN that House Staff may begin the procedure and of the expected arrival time of an attending surgeon. House Staff will be responsible for knowing their limitation based on their level of training.

2. If the attending surgeon cannot be contacted, the attending anesthesiologist may determine that the case is emergent and that House Staff may begin the procedure. House Staff will be responsible for knowing their limitation based on their level of training. The attending anesthesiologist will directly inform the charge RN that House Staff may begin the procedure.

F. Surgeons must be in the operating room and ready to commence surgery prior to the time scheduled in accordance with operating room policies and procedures.

G. Patients having symmetrical site surgery will have the correct surgical site identified and marked prior to any incision being made in accordance with applicable Hospital and operating room policies and procedures.

H. A surgical timeout will occur prior to the surgical incision or start of the procedure in accordance with applicable Hospital and operating room policies and procedures.

I. All previous orders written for a patient are not effective while the patient is in the operating room but may be resumed postoperatively. The House Staff, APP, or attending Practitioner are responsible for reviewing and resuming suspended orders postoperatively.

J. Anesthesia personnel shall maintain a complete anesthesia record as described in the policies and procedures of the Department of Anesthesiology, as such policies and procedures may be amended from time to time.

K. An operative or other high-risk procedure report must be entered in the electronic medical record immediately after an operation or other high-risk procedure unless a brief operative/procedure note is entered into the

electronic medical record in accordance with Section 1.13 (L)in which case the detailed operative or other high-risk procedure report must be entered in the electronic medical record within three (3) days following the surgery or other high-risk procedure. The detailed operative or other high-risk procedure report must contain:

1. Name and hospital identification number of the patient

2. Date and time of the procedure

3. Person performing the procedure and any assistants

4. Preoperative diagnosis

5. Postoperative diagnosis

6. Specific procedure performed

7. Type of anesthesia administered, if any

8. Complications, if any

9. Estimated blood loss

10. A full description of the procedure techniques and findings, specimens, and tissues removed or altered

11. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any

12. Tasks performed by Practitioners other than the primary Practitioner

L. If the operative or high-risk procedure report required by Section 1.13 (K) is not placed in the electronic medical record immediately following the procedure, then a brief operative/procedure note must be immediately entered into the electronic medical record after the surgery or procedure and before the patient is transferred to the next level of care. If a brief operative/procedure note is utilized, it must include, at a minimum:

1. Procedure performed

2. Person performing procedure/assistants

3. Specimens removed, if applicable

4. Complications, if any

5. Description of procedure findings

6. Estimated blood loss

7. Postoperative diagnosis

M. Operative/procedure reports and brief operative/procedure notes may be dictated or entered directly into the electronic medical record using the "procedure note" type. Dictated reports/notes must be authenticated through the electronic medical record system.

N. All tissue specimens removed during a surgical procedure will be sent for pathologic examination to the Hospital Department of Pathology & Laboratory Medicine except (1) those specimens that may be exempt from this requirement under the policies of the operating room and/or the Hospital's Department of Pathology & Laboratory Medicine Procedure AP-SUR-5.6, and (b) those surgical specimens collected under an IRB approved protocol allowing for the direct access and transfer of an otherwise exempt tissue specimen to a clinician researcher without pathology examination or review. A Hospital pathologist will make such examinations as he/she may consider necessary to arrive at a pathological diagnosis.

O. In consultation with the pathologist on duty, the surgeon and the pathologist may agree that certain specimens do not require pathologic examinations. The listing of specimens automatically exempted from examination in the Hospital's Department of Pathology and Laboratory Medicine Procedure AP-SUR-5.6, shall be mutually agreed upon and periodically reviewed (usually every two (2) years) and updated by the Chief of the Department of Pathology & Laboratory Medicine and the Surgeon-in-Chief. The pathologist shall sign his/her report on specimens he/she has examined.

P. When specimens are removed for special laboratory procedures other than histopathology, the studies and their results will be recorded with the Department of Pathology & Laboratory Medicine. The Hospital pathologist shall be notified prior to removal of the specimens when the study includes gross anatomic evaluation of a portion of the specimen. The Practitioner primarily responsible for the patient's care, in consultation with the pathologist on duty, will determine the priorities for use of the specimen removed.

Q. The Surgeon-in-Chief shall automatically suspend the surgical/procedure Privileges of any surgeon who fails to record in the electronic medical record an operative or other high-risk procedure report within three (3) days following the procedure. The automatic suspension will be in effect until the operative or other high-risk procedure report is completed. In the event an emergency surgical case arises during the period that the Practitioner's surgical Privileges are automatically suspended, the

automatic suspension will be temporarily lifted for the care of that particular emergency case.

R. When a surgeon wishes to use an operating room previously scheduled by another Practitioner, it shall be the responsibility of that surgeon to personally contact the Practitioner who originally scheduled the room and secure permission for this change. Exceptions will be made only in cases of life-threatening or limb-threatening emergencies.

S. Operative procedures shall be scheduled in conformance with the Privileges granted to the surgeon.

T. Scheduling policies, rules, and regulations, and changes thereto, for the operating room shall be reviewed and approved by the Hospital OR Block Committee and Perioperative Safety Committee, as applicable. All approved rules and regulations of the operating room shall be available in the operating room supervisor's office.

U. All operative procedures performed in the operating room will be under the supervision of the Surgeon-in-Chief.

1.14 Rules for Emergency Department Care

A. The Hospital shall maintain an Emergency Department with emergency services available twenty-four (24) hours a day. The responsibility for emergency care shall be given only to Practitioners or APPs with appropriate Privileges at the Hospital or House Staff.

B. The duties and responsibilities of all personnel serving patients within the Emergency Department shall be defined in a policy and procedure manual which will be readily available in the Emergency Department.

C. The policies and procedures of the Emergency Department are developed and recommended by the Section Chief of Emergency Medicine, Nurse Director, and the Administrator for Ambulatory Services and approved by the Chief Medical Officer and the Medical Executive Committee. All Emergency Department policies impacting patient care or affecting the practice of Practitioners or APPs with Privileges at the Hospital shall be sent to the Medical Executive Committee for approval.

D. An appropriate medical record shall be kept for every patient receiving Emergency Department services and shall be incorporated into that patient's electronic medical record. Other Emergency Department records shall be kept on file either in original form or in the electronic medical record. The content of the Emergency Department record is set forth in Section 1.12 (P)(1) of this Policy.

E. Each patient's Emergency Department medical record shall be dated, timed, and authenticated by the Practitioner in attendance who is responsible for its clinical accuracy.

F. Emergency Department medical records shall be reviewed regularly by those responsible for the operation of the Emergency Department and by the Medical Records Department. Medical records requiring further review of medical judgments and records of patients who die within the first twenty-four (24) hours who have been received through the Emergency Department shall be regularly reviewed by the Section Chief of Emergency Medicine.

G. The patient's personal primary care Physician, subspecialist, or Dentist, Podiatrist, or Psychologist (as applicable), if able to be determined under the circumstances, or their designee, will be contacted if such Practitioner is a Member of the Medical Staff, referred the patient to the Emergency Department, if follow-up care needs to be arranged, or if the patient is admitted to the Hospital.

H. If a consult was completed in the Emergency Department immediately prior to admission, that consult note may serve as the admission H&P subject to completion and documentation of an update thereto in accordance with the requirements set forth in the Medical Staff Bylaws and this Policy.

1.15 Guidelines for Written Informed Consent

A. Guidelines for obtaining and documenting informed consent are set forth in Patient/Family Care Policy Number 15:30 (Consent – Relationships and Requirements), as such policy may be amended from time to time.

1.16 Qualified Medical Personnel Who May Perform Medical Screening Examination

A. Designation of qualified medical personnel who may perform a medical screening examination to determine if an emergency medical condition exists, and guidelines related thereto, are set forth in the following Hospital policies: (1) Administrative Policy Number III-9 (Emergency Medical Treatment and Active Labor Act); and (2) Administrative Policy Number VIII-8 (Emergency Medical Treatment of Adults), as such policies may be amended from time to time.

ADOPTION & APPROVAL

Adopted by the Medical Executive Committee on May 21, 2024

Approved by the Hospital Board on May 31, 2024