RULES AND REGULATIONS

ADMISSIONS

1. Patients may be admitted to the Hospital only by members who are in good standing on the Honorary, Active or Courtesy Staff.

2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In an emergency situation, the provisional diagnosis shall be stated as soon after admission as possible. Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

3. It is the sole responsibility of the admitting or referring physician to notify the attending physician of a patient's need for admission to the Hospital. If for some reason the referring physician cannot contact the attending physician, the patient should be referred to the Emergency Medicine Department for evaluation and admission, if appropriate.

MEDICAL RECORDS

1. Preparation and Completion – Members of the Medical and Dental Staff shall ensure that their documentation in the medical record is legible, timely, and accurate. The medical record must contain sufficient information to identify the patient; support the diagnosis; justify the treatment; document the course and results; and facilitate continuity of patient care.

   (a) Documentation Content: The medical record shall contain objective and relevant documentation that pertains to the direct care of the patient. The following should not be documented within the medical record:

      1. Reference to an Event Report.
      2. Statements criticizing or demeaning to the patient, the family, other care givers.

   (b) The use of unapproved abbreviations is not permitted. Only approved abbreviations should be used in the medical record. The unapproved and approved abbreviation lists for Lancaster general Hospital are located on the Intranet.

   (c) The medical record must be completed within thirty (30) days of discharge. For purposes of monitoring delinquent medical records for regulatory and accrediting agencies, incomplete medical records greater than 21 days post-discharge will be considered delinquent. No medical record shall be considered complete until all assigned deficiencies have been completed.

   The process of notifying physicians of medical record status will be approved by the Medical Executive Committee and administered by the Health Information Management Department. Suspension of clinical privileges may occur when a physician has incomplete medical records that are older than 28 days post-discharge.

   Clinical privileges will automatically be reinstated if delinquent records are completed within thirty (30) days of the suspension. After thirty (30) days, the suspended member will be required to reapply for clinical privileges and appointment under Article Five in these Bylaws. The President of the Medical and Dental Staff will provide written notification to those members whose clinical privileges are being suspended. In the event of such a suspension, the procedure for assigning the responsibility for the care of patients as set forth in Article Six, B, shall apply.

However, members whose clinical privileges are suspended for failure to complete medical records shall not be entitled to a hearing or appeal under Article Ten of these Bylaws.

2. Ownership of the medical record - All medical records are the property of the Hospital and shall not be removed from the Hospital except in response to a properly executed subpoena, court order, statute, or for some special reason if approved by the President of the Hospital, or his designee. In case of re-admission of a patient, prior medical records shall be available for the use of those members of the Medical and Dental Staff involved in the care of the patient.

3. History and Physical Examination

(a) A history and physical examination shall be documented within the health record within twenty-four (24) hours of inpatient admission or outpatient observation, and within twenty-four (24) hours prior to procedures involving moderate sedation, anesthesia services or any high risk procedure list under letter (f) of this section.

History and Physical (H&P) reports completed by allopathic or osteopathic physicians who are not members of the Hospital's Medical and Dental Staff or by first year residents or physician assistants, as per Pennsylvania Code requirements, are acceptable only if signed by the professional completing the H&P and counter-signed by the attending physician. Complete history and physical documentation is not required for normal newborns and vaginal delivery patients. Labor/Delivery/Newborn records may serve as the history and physical for a normal newborn and the prenatal record for a vaginal delivery.

Minimum Requirements for H&P Reports:

- Chief Complaint
- History of Present Illness
- Relevant Past Medical History
- Relevant Family History
- Relevant Social History
- Pertinent data including drug allergies and medications
- Physical Examination-include relevant positive and negative findings
- Diagnostic Impressions and Plans

(b) H&P Report update requirements

An H&P Report may be utilized if it has been performed within thirty (30) days prior to admission, observation, or procedures and is consistent with the minimum requirements established for H&P Reports.

All H&P Reports done prior to inpatient admission, observation, or above referenced procedures must be updated within 24 hours of admission, observation, or outpatient procedures noted in (a)(and prior to these outpatient procedures) . Updates may be added to the Progress Notes, by amending the H&P, or Consult Note with an interval note in the electronic health record. The update is to assess and document, if there has been any change to the health status of the patient since the H&P was performed and/or to assess any areas where more current data was requested or available. The provider uses his/her clinical judgment based on assessment of the patient's medical condition and medical history when deciding the depth of the assessment that needs to be performed and what information needs to be included in the updated note.

(c) If the preadmission history and physical examination is older than thirty (30) days, a complete history and physical examination report must be recorded in the medical record meeting the timeframes specified on(a)above.

(d) When the history and physical examination is not documented prior to the time stated for an operative or invasive procedure, the procedure shall be canceled unless the physician documents in the medical record that such delay would constitute a hazard to the patient (i.e. extreme emergency).

(e) Extreme emergency and minimum pre-operative requirements:

Extreme emergency is defined as any circumstance that is an acute threat to life, organ, or limb and the physician has documented the nature of the emergent situation. The preoperative diagnosis shall be documented and the appropriate communication to the Operating Room personnel or other specialized interventional units and Anesthesia. Complete documentation shall be recorded as soon as possible thereafter.

(f) H&P (as described above (a)-(e)) is required for the following High Risk procedures (in addition to all those involving moderate sedation and\or anesthesia services):

- Amniocentesis
- Catheter directed angiography
- Invasive Angiography
- Angioplasty and stenting procedures
- Bone marrow biopsies
- Tunneled catheter exchange
- Primary Central line placement (includes PICC)
- Primary Chest tube placement
- Deep (intraperitoneal or retroperitoneal) aspiration
- Deep fine needle or deep core biopsy procedures (includes bone)
- External cephalic version
- Intravascular device placement
- Intravascular tPA and embolization procedures
- Liposuction
- Paracentesis
- Percutaneous cardiovascular diagnostic and interventional procedures
- Primary Percutaneous drainage except collections contained within subcutaneous fat
- Primary Percutaneous Nephrostomy tube placement
- Percutaneous Transhepatic Cholangiogram
- Percutaneous transhepatic biliary drainage catheter placement or exchange
- Primary Percutaneous tube placement in GI tract
- Percutaneous sclerosing and ablative procedures within the chest, abdomen or pelvis
- Thoracentesis
- Elective Cardioversion
- Transesophageal echocardiogram

4. ORDERS

(a) Standing orders may be formulated by the various departments. Standing orders shall be approved by the Pharmacy and Therapeutics Committee. No standing orders may include orders for the administration of narcotics. Specific orders for patients take precedence over standing orders, which constitute orders for treatment, only in the event the attending staff member does not have more specific orders.

(b) All orders for treatment shall be complete in the electronic medical record by the responsible practitioner. Only members with clinical privileges in this Hospital and residents may document orders within the medical record. Medical affiliates may provide orders consistent with licensure restrictions and written collaborative agreement.

(c) Oral or written orders for medication or treatment shall be accepted only when it is impractical for such orders to be entered into the electronic medical record by the responsible practitioner. Oral orders shall be taken only by qualified personnel who shall add the orders in the proper place in the medical record of the patient. Each oral order shall include the date, time, full signature and title of the person taking the order, shall be read-back to and verified with the ordering provider and shall be countersigned by the prescribing physician or dentist or his designee within seven (7) days.

The following are authorized to accept oral orders for treatment or medication within each respective professionals' scope of practice:

(1) residents;
(2) registered nurses;
(3) graduate nurses;
(4) physical therapists;
(5) respiratory therapists;
(6) pharmacists;
(7) speech-language pathologists;
(8) nurse practitioners;
(9) physician assistants;
(10) certified registered nurse anesthetists;
(11) registered dietician nutritionists;
(12) occupational therapists;
(13) radiology technologists;

Oral orders may not be issued or accepted for initiation of antineoplastic agents.

(d) Stop-order on drugs: All drug orders for narcotics, sedatives, hypnotics, and anti-coagulants shall be discontinued automatically after 48 hours and antibiotics after five days unless:

(1) the order indicates an exact number of doses to be administered;
(2) an exact period of time for the medication to be administered; or,
(3) the attending staff member re-orders the medication.

5. Progress Notes

(a) Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever 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. Daily progress notes by the attending physicians are desirable. Progress notes shall be documented at least daily on the critically ill patients and those where there is difficulty in diagnosis or management of a clinical problem.

(b) Progress notes shall be dated, timed, signed, and entered on the medical record on the day of the visit to the patient. Retrospective progress notes are to be discouraged. In the unusual occasion in which a retrospective progress note may become necessary, the member shall record the date of the writing, the actual date(s) the patient was visited, and the reason for the delay in recording such retrospective progress note.

6. Operative and Procedure Notes

(a) Minimum preoperative diagnostic studies shall be delineated by the Department of Anesthesiology and the Department of Surgery.

(b) A post-procedure note must be documented immediately following the operation or procedure and include the following elements:

1. The name of the Procedure performed
2. A description of the procedure
3. The name(s)of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
4. Any estimated Blood Loss
5. Findings of the procedure
6. Any specimen(s) Removed
7. The Post-Operative Diagnosis

(c) All operative and invasive procedure notes shall be dictated or completed within the electronic health record immediately upon completion of the procedure and shall contain a description of the findings and a detailed account of the technique used and tissue removed. This includes procedures performed in the operating room, endoscopy suite, radiology and diagnostic imaging, and designated procedures performed in the cardiac catheterization laboratories.

(d) All appliances, tissues and foreign bodies removed at operation shall be sent to the hospital pathologist who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis. Specific exceptions may be granted by the Medical Staff utilizing the following mechanism:

Surgical Specimens: On an annual basis, or on special request submitted to the Invasive Procedure Appraisal Committee, the Invasive Procedure Appraisal Committee, in conjunction with the Department of Pathology, shall review and delineate in writing those tissues, materials, or exudates removed during a surgical procedure that do not need to be sent to the laboratory for pathological examination. Those surgical specimens not requiring submission for pathological examination shall be determined in compliance with the Commonwealth of Pennsylvania Code of Regulations governing the Licensure of Hospitals, specifically 28 Pa. Code §135.15. The list of surgical specimens excluded from pathological submission shall be included in the written Operating Room Structure Standards Manual maintained in the Main Operating Room and in the Procedure Manual of the Department of Pathology, and published annually in the minutes of the Executive Committee of the Medical and Dental Staff.

Foreign object of forensic significance, such as a missile or weapon, may be handed directly to a responsible law enforcement official, if present, and so noted in the medical record.

7. CONSULTATIONS

(a) Consultation may be declared to be mandatory in certain clinical situations or diseases. Such requirements shall be delineated in these rules and regulations or in those of the respective departments.

(b) Guidelines of a consultation: Consultations shall be dictated or completed within the electronic health record, authenticated by the consultant, and should include:
(1) Reference to chart review
(2) Patient examined
(3) Impression/Recommendations

The patient is to be seen within twenty-four (24) hours of notification unless otherwise stated in the consultation order. An opinion signed by the consultant shall be recorded in emergency or urgent situations. When operative procedures are involved, the

consultation note, except in an emergency, shall be recorded prior to the operation.

(c) Responsibility for requesting consultations: The patient's attending physician is responsible for requesting consultations when they are indicated. He should present the problem upon which the consultant's opinion is desired. He should stipulate whether he wishes a consultation, wishes the consultant to follow the patient with him, or wishes to transfer the patient to the consultant's service.

(d) The attending physician responsible for the care of the patient shall be responsible for judgments as to the serious nature of the illness and any questions of doubt as to diagnosis and treatment.

(e) It is the duty of the Staff through its Department Chairmen and Executive Committee to make certain that members of the Staff request consultations when needed.

(f) Both Physician Assistants and Certified Registered Nurse Practitioners can dictate or complete the consultation report in the electronic health record only after the case has been presented to the physician and the supervising physician has reviewed the chart and evaluated the patient. All dictated or electronic health record notes should state specifically that the physician saw and evaluated the patient and discussed the plan of care.

8. DISCHARGES AND THE DISCHARGE SUMMARY

(a) Attending physicians are responsible for evaluating the disposition of the patient early enough so that appropriate planning may be accomplished by both the patient and Hospital personnel. Patients should be advised of their discharge by the attending physician or nursing personnel in sufficient time for them to make necessary arrangements to comply with Hospital policy.

(b) Any patient leaving the Hospital against the advice of the attending staff member shall be requested to sign a statement releasing the Hospital and the Staff member from any responsibility. In the case of a minor, such a statement should be executed by his legal representative. In cases where this request is denied, the Staff member shall so state in the record.

(c) A discharge summary shall be dictated or completed in the electronic health record of each hospitalized patient, including observation patients. Any inpatient who dies in the hospital shall have a dictated or electronic health record death summary.

The discharge summary should include, at a minimum, the following:

1. Reason for hospitalization
2. Significant findings
3. Procedures and care, treatment and services provided
4. Patient’s condition at discharge
5. Medications dispensed or prescribed on discharge
6. Discharge instructions to the patient and/or family
7. Provisions for follow-up care
8. Patient’s discharge disposition

The completion of the Newborn Discharge Summary form shall be sufficient for normal newborn infants. If such form is not completed, a newborn discharge summary shall be dictated or completed in the electronic health record. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

(d) Co-signatures by attending physician are required on all discharge summaries completed by first year residents.

INFORMED CONSENTS

1. It shall be the responsibility of each Staff member or physician designee to obtain informed consents for any treatment or procedure he may perform for which consent is required. The risks, benefits and alternatives shall be explained to the patient. Consents for treatment or procedure shall be documented on forms provided for that purpose by the Hospital whenever possible. If consent cannot be obtained in writing prior to the treatment, e.g., an emergency condition, the reasons shall be stated by the Staff member in the patient's record.

2. A surgical operation shall be performed only on consent of the patient or his legal representative. In emergencies, if the patient is unconscious or incapable of making a decision and there is not sufficient time to locate a relative who can authorize the procedure, the requirement for informed consent can be waived.

SURGICAL STERILIZATION

1. If an operation to accomplish sterilization is recommended by the physician for medical indication, the recorded opinion of a knowledgeable consultant is required.

2. If sterilization is requested by the patient and the attending physician agrees, consultation is not necessary.

3. In all cases where primary sterilization is to be performed, or where sterilization may result from an indicated operation, it is important that the patient understand that any subsequent attempt at restoration of fertility is unlikely to be successful.

ABORTION

1. Abortion may be performed in accordance with the laws of the Commonwealth of Pennsylvania.

2. No physician shall be required to perform, nor shall any patient be forced to accept an abortion. If an operation to accomplish termination of pregnancy is recommended by a physician for medical indications, the recorded opinion of a knowledgeable consultant is required.

ADOPTION

1. No member of the Staff shall in any way act as an intermediary or place an infant in a free foster home or in any family for the purpose of adoption, except through an agency licensed for adoption by the Commonwealth of Pennsylvania.

AUTOPSIES

1. Permission to perform an autopsy should be sought by a member of the Medical and Dental Staff when an autopsy might provide a significant health care or educational purpose. Examples of this include:

   (a) Death in which autopsy may explain unanticipated medical or surgical complications to the attending physician or the family.

   (b) Deaths at any age in which it is reasonably believed that an autopsy would disclose a suspected illness which may have a bearing on survivors or recipients of transplant organs. In these cases the attending physician or his/her designee should approach the legal next of kin for permission for an autopsy and so document in the medical record.

2. In addition, the following cases should be referred to the Lancaster County forensic medical jurisdiction (the Coroner or his designee):

   (a) Unexplained deaths occurring during or immediately following any dental, medical or surgical diagnostic procedure and/or therapy.

(b) Other unexplained deaths including:

1. Persons dead on arrival at hospital
2. Unexplained death occurring with twenty-four hours of admission
3. Deaths in which the patient sustained or apparently sustained an injury while hospitalized
4. All obstetrical deaths
5. All Code T deaths

3. The attending physician should discuss the case and the reason for autopsy with the pathologist prior to the autopsy being performed. The pathologist should report his findings to the attending physician as soon as possible after completion of the autopsy. The final autopsy report shall be completed within 90 days.

4. No autopsy shall be performed without a legally valid consent. All autopsies shall be performed by a hospital pathologist or by a physician to whom he may delegate the duty.

INFECTIONS

1. Attending physicians are required by the Pennsylvania Department of Health to report all cases of communicable diseases. A list of the reportable diseases is available on the Infection Control StarNet page under the Infection Control Manual, Section 1. The Infection Control Practitioners are responsible for reporting these to the Department of Health.

2. Methods of control of in-hospital infections:

   a. Standards as set forward by the Infection Control and Prevention Committee of the Hospital for the control and prevention of infections shall be followed.

   b. All hospital acquired infections are reported via the electronic health record to The National Healthcare Safety Network, division of the Center for Disease Control and Prevention per Act 52 of 2007 of the Pennsylvania State Legislature with written notification to the patient.

MANDATORY REPORTING OF SERIOUS EVENTS

As a health facility, mandated reporting of certain events are required by law. Failure to report these events can result in fines to the institution. When these events occur, providers are required by the Pennsylvania Department of Health/Joint Commission to report such events.

1. Act 13 – Medical Care Availability and Reduction of Error (MCARE) – which established the Patient Safety Authority and requires patient safety reporting. Based on this Act, all serious events require reporting to the Patient Safety Authority. Willful failure to report will cause Lancaster General Health to report a licensed health care professional to his/her respective state professional licensure board in accordance with Pennsylvania's Medical Care Availability and Reduction of Error Act (Act 13).

2. Act 52 of 2007 of the Pennsylvania State Legislature - All hospital acquired infections are reported via the electronic health record to The National Healthcare Safety Network, division of the Center for Disease Control and Prevention with written notification to the patient.

DIETS

1. The Hospital Diet Manual is maintained on the Intranet (StarNet) and is available to all employees 24 hours per day, seven days a week. This manual is reviewed annually by the clinical nutrition staff and the dates of all revision are indicated. Hospital diets that are ordered by members of the Medical & Dental Staff are selected from this manual.

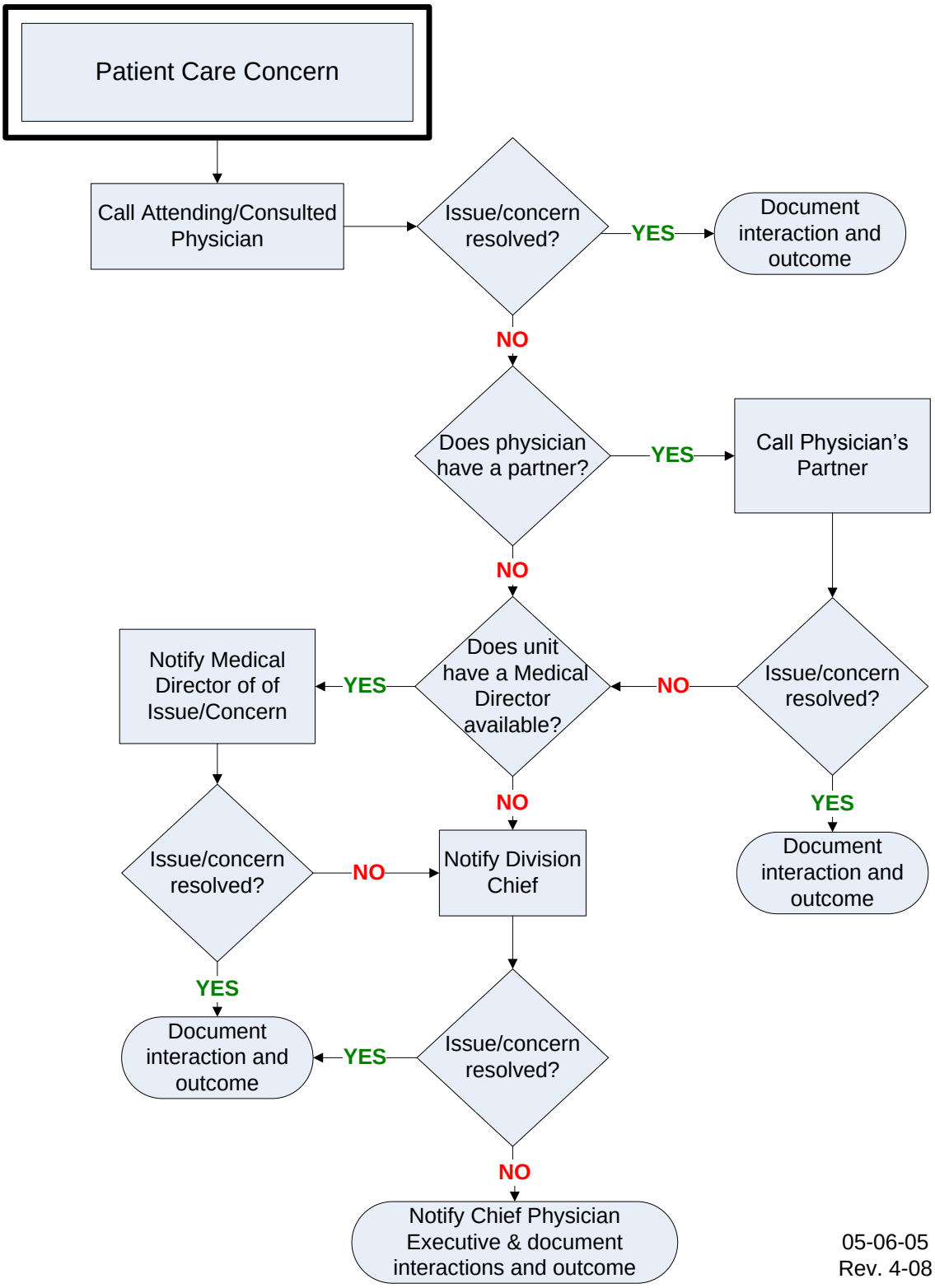
2. Every patient should have a diet order included in his\her admission orders, including NPO order when appropriate. If a diet order is not included in the admission orders, one should be obtained prior to the next meal.

3. Nutrition Education Consultations should be ordered 24 hours before the estimated discharge date so that adequate consultation time may be arranged between the dietitian and the patient.

ALTERNATE STAFF MEMBER DESIGNATION

Each member of the Staff shall designate a Staff member who may be called to attend his patients in an emergency. If the named Staff member is unavailable, or if no Staff member has been designated, the appropriate Department Chairman or his designee is authorized to call upon any member of the Staff to provide necessary treatment.

PATIENT CARE CONCERN



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Rev. 4-08

MEETING ATTENDANCE REQUIREMENTS

Active Staff Members are required to attend two Medical and Dental Staff Meetings per calendar year.

SUPERVISION OF RESIDENTS

The Medical and Dental Staff assures that each resident in the Family Practice Residency Program is supervised in his/her patient care responsibilities by a licensed independent practitioner, who has been granted clinical privileges through the medical staff process. Written descriptions of the role, responsibilities, and patient care activities of the residents in the Family Practice Residency Program is provided in the Residency Education Evaluation Project/Policy Manual and are provided to the members of the Medical and Dental Staff responsible for supervision of the Family Practice residents.

The supervisory responsibilities of teaching physicians are delineated in the Residency Education Evaluation Project/Policy Manual.

Written evaluations are completed by the supervising Medical and Dental Staff member and forwarded to the Program Director of the Family Practice residency program. These evaluations are reviewed with the residents on a tri-annual basis by each resident's faculty advisor who also conducts and prepares a written formative and summative evaluation; these evaluations are forwarded to the Program Director of the Family Practice residency program who conducts annual performance reviews of each family practice resident. The Program Director of the Family Practice residency program communicates to the Graduate Medical Education Committee regarding failure of any resident to meet the program requirements relating to progressive involvement and independence in specific patient care activities. This information is included in the Biannual Report presented to the Medical Executive Committee of the Medical and Dental Staff by the Program Director of the Family Practice residency program.