Lowell General Hospital

Complete connected care℠

MEDICAL STAFF RULES & REGULATIONS

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DEFINITIONS

The following definitions apply to the provisions of these General Rules and Regulations for the medical staff. The definitions are in alphabetical order.

1. ALLIED HEALTH PROFESSIONAL means an individual, other than a licensed physician, dentist, oral surgeon, or podiatrist, who exercises independent judgment within the area of their professional competence and who is qualified to render direct or indirect medical, dental, podiatric, or surgical care under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. Such Allied Health Professionals shall include clinical psychologists, nurse practitioners, nurse anesthetists, medical physicists, physician assistants, certified nurse midwife, and any others recommended by the Medical Executive Committee and approved by the Board of Trustees.

2. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Board of Trustee to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him.

3. EX OFFICIO means service as a member of a body by virtue of the office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

4. HOUSE STAFF means residents, fellows, and medical students of an approved medical school with an affiliation with the Hospital.

5. HOSPITAL means Lowell General Hospital

6. MEDICAL STAFF or STAFF means that component on the hospital chart of organization that stands for all practitioners, as defined in number 7 below, who are appointed to membership and are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the hospital.

7. MEDICAL ANCILLARY STAFF includes Dentists, Podiatrists, and Allied Health Professionals.

8. MEDICAL STAFF MEMBER IN GOOD STANDING or MEMBER IN GOOD STANDING means a practitioner who has been appointed to the medical staff or to a particular category of the staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws and related manuals or any other policies of the medical staff of the hospital.
9. PHYSICIAN means an individual with an M.D. or D.O. degree, who is licensed to practice medicine.

10. PRACTITIONER means, unless otherwise expressly provided, any physician, dentist, oral surgeon, or podiatrist, who either: (a) is applying for appointment to the medical staff and for clinical privileges; or (b) currently holds appointment to the medical staff and exercises specific delineated clinical privileges; or (c) is applying for or is exercising temporary privileges pursuant to the Medical Staff Bylaws.

11. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional and exercisable subject to the ultimate authority of the board and to the conditions and limitations imposed in the Medical Staff Bylaws and related manuals and in other hospital and medical staff policies.

12. PRINCIPALS means anyone involved in the care of the patient or having reason to know the patient's wishes.

GENERAL INTRODUCTION

1. These General Rules and Regulations relate to role and/or responsibility of members of the medical staff and individuals with clinical privileges in the case of inpatients, emergency care patients, and ambulatory care patients.

2. Rules of the Medical Staff will not conflict with the Medical Staff policies or bylaws, the Hospital corporate bylaws, state, federal, or regulatory agencies, or Lowell General Hospital Administrative policies.

PATIENT RIGHTS

The Lowell General Hospital and the medical staff organization respect the rights of each patient, and recognize that each patient is an individual with unique health care needs. Therefore, in order to affirm the rights of the patients. The policy and procedure, Policy on Patient Rights and Responsibilities is attached as Appendix A.

PART ONE: ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

1.1-1 Patients shall be admitted without regard to race, creed, color, sex, sexual orientation, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Chief Executive Officer/designee after consultation with the appropriate Administrative Staff.

1.1-2 The hospital shall admit eligible patients suffering from any type of disease which, in the opinion of the admitting physician, can be adequately cared for at this hospital and shall admit and treat any person for humanitarian purposes until such time as the patient may be safely transferred to another hospital.

1.2 GENERAL ADMISSION RULES

1.2-1 A patient shall be treated only by staff members who have submitted proper credentials and have been duly appointed to membership on the Medical Staff except as otherwise provided by the Medical Staff bylaws of Lowell General Hospital.

1.2-2 No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

1.2-3 In any emergency case, in which it appears that the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

1.2-4 Practitioners admitting emergency cases shall be prepared to justify (to the Medical Executive Committee and to the administration of the Hospital) that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission.

1.2-5 A patient to be admitted on an emergency basis who does not have a patient-practitioner relationship with a medical staff member at the hospital may select any practitioner in the applicable department or service to attend to them. Where no such selection is made, a member of the active or affiliate staff on duty from the appropriate department or service on a rotation basis shall be assigned to the patient. The chairman of each department shall provide a schedule for such assignments.

1.2-6 Practitioners may admit a patient to the service of another practitioner when

there is a prior agreement and approval of both practitioners (e.g. coverage groups). The practitioner issuing the order to admit remains responsible for all care rendered to the patient until the covering practitioner physically attends to the patient or issues a verbal or telephone order acknowledging his/her responsibility for the patient's care.

1.2-7 Practitioners admitting patients shall be responsible for giving such information known to them as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatsoever.

1.2-8 All members of the Medical Staff shall provide care regardless of patient's ability to pay.

1.3 ADMITTING PREROGATIVES

1.3-1 GENERAL REQUIREMENTS

Only a member of the medical staff in good standing may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the hospital as may be in effect from time to time. Practitioners with the privilege to admit to inpatient services may do so in accordance with state law and the standards of medical care established by the medical staff. The Medical Staff Office shall maintain with the Admitting Office a current list of medical staff allowed to admit to the hospital along with any limitations.

1.3-2 STAFF PRIORITIES WHEN RESOURCES STRAINED

At times of full hospital occupancy or of shortage of hospital beds or other facilities, as determined by the Chief Executive Officer or their designee, priorities among the members of the various staff categories for access to beds, services or facilities for patients of similar status (i.e., elective, urgent, emergency) are as follows:

1. Active Staff members in good standing.
2. Affiliate staff members in good standing.

When two or more practitioners with the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received. The Chief Executive Officer or their designee shall instruct the Admitting Office of the logistics needed to implement this section.

1.3-3 LIMITATIONS FOR DENTISTS AND PODIATRISTS

DEFINITIONS

A Podiatrist is a graduate of a School of Podiatric Medicine approved By the Council of Education of the American Podiatry Association, and who is legally licensed to practice in Massachusetts. The practice of Podiatry is limited to the examination, diagnosis, treatment, and care of the condition and functions of the human foot as prescribed by the laws of the Commonwealth of Massachusetts.

A Dentist is a graduate of a dental school approved by the Council of Education of the American Dental Association and thus holds a Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.) degree and is legally licensed to practice in Massachusetts. The practice of dentistry is limited and prescribed by the laws of the Commonwealth of Massachusetts.

An Oral Surgeon is a dentist who has completed a residency or fellowship in oral surgery approved by the Council of Education of the American Dental Association. The practice of oral surgery is limited and prescribed by the laws of the Commonwealth of Massachusetts.

GENERAL RULES

The Podiatry Staff shall be directly responsible to the Chief of the Department of Surgery. A podiatrist may initiate the process for admitting a patient, but a physician member of the Medical Staff must perform a comprehensive history and physical examination of each patient either prior to or immediately after admission. Podiatrist or oral surgeons may write the admission note addendum. The physician member or their designee will then be responsible for the care of any medical problems that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Chief of the Department of Surgery. An oral surgeon with the requisite qualifications may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient, but only in those instances where the patient has no known current medical problems. In all other circumstances, a physician member of the Medical Staff shall be consulted to perform a comprehensive history and physical on their oral surgery or dental patients prior to any procedure. If the patient requires hospitalization, the patient will be admitted to the medical physician responsible for the H&P or their designee. When a significant medical abnormality is present prior to surgery, the final decision on whether to proceed with surgery must be agreed upon by the oral surgeon, dentist, or podiatrists and

anesthesia. The Chief of the Department of Surgery will decide the issue in case of dispute.

The oral surgeon, dentist, or podiatrist, shall assume the responsibility for the management of a case consistent with the Standards of the Joint Commission, the bylaws of the Medical Staff of Lowell General Hospital and these Rules and Regulations.

If post-op admission to the hospital is expected, it is the responsibility of the oral surgeon, dentist or podiatrist, to notify the responsible medical physician or his designee ahead of time.

History and Physicals from non-medical staff members will not be accepted.

The appropriate Department Chief shall enforce all Rules and Regulations.

MEMBERSHIP

Members of the Podiatry, Oral Surgery, and Dental Staff shall meet all the requirements of the Medical Staff that are applicable, as defined within the Medical Staff Bylaws, these Rules and Regulations, and related manuals and policies.

All applicants to the Podiatry, Oral Surgery, and Dental staff must conform to the same procedures that are outlined in applicable sections of the Medical Staff bylaws.

1.4 ADMISSION PRIORITIES BASED ON PATIENT CONDITION

Before the assignment of daily admissions, available beds are assigned for the transfer of patients in the following priority based upon consideration of patient safety and need:

- Emergency patients awaiting beds.
- Admitted Ambulatory Surgery patients awaiting beds.
- Elective surgical or surgical patients whose admissions are urgent in nature and cannot be safely postponed.
- Scheduled Elective Admissions
- Current Day Elective Admissions

1.4-1 EMERGENT CONDITION - FIRST PRIORITY

The attending practitioner may declare a case an emergency. Prior to referral of

an emergency patient for admission to the hospital, the attending practitioner must, when possible, call the Admitting Office to determine bed availability.

For each patient admitted as an emergency, the attending practitioner must provide the following documentation or information within the time frames indicated:

Within 8 eight hours of the patient's admission to the Hospital, an admission note which indicates involvement in the immediate care for the patient, provides an admitting diagnosis, and provides the reason for the emergency admission.

An exception to this is if a patient's life is at risk and care requires a high level of care such as an ICU or IMC level admission. The admitting physician or designee is expected to fully evaluate the patient in two hours which would include a full examination and placing of orders.

1.4-2 ADMITTED AMBULATORY SURGERY PATIENTS AWAITING BEDS- SECOND PRIORITY

A patient who has been admitted to Ambulatory Surgery and requires a bed for post-operative care shall receive second priority in the event of limited bed availability.

1.4-3 URGENT CONDITION - THIRD PRIORITY

- An urgent admission is an admission that is imminent because outpatient therapy has been unsuccessful and the only alternative therapy is as a hospital inpatient.

  The attending practitioner must document, as part of their request for an urgent admission, the specific reason for admission supportive of the request and the degree of urgency involved.

1.4- 4 SCHEDULED ELECTIVE ADMISSIONS – FOURTH PRIORITY

- An elective admission is an admission in which the patient's medical condition permits adequate time to schedule suitable accommodations to provide therapy as a hospital inpatient.

- This category includes all elective medical and surgical patients scheduled in advance. When all such admissions for a specific day are not possible, the CMO will review the cases listed in the Admitting Office and determine the priority.

- Elective admissions can be scheduled any day of the week if intensity of

service and severity of illness criteria are met.

1.4-5 CURRENT DAY REQUESTS FOR ELECTIVE ADMISSIONS - FIFTH PRIORITY

This category includes all elective admissions that are not covered under section 1.4-5 or 1.4-2.

1.5 ADMISSIONS DURING PEAK CENSUS

1.5-1 PURPOSE

To ensure the appropriate and timely admission of patients during peak census and to ensure the availability of emergency beds.

1.5-2 POLICY

The Hospital will provide a mechanism through which emergency patients are admitted when a high census exists.

The CMO and the Executive Vice President and COO, and the VP of Patient Care Services and Chief Nurse Executive shall serve as a "Medical Screening Committee" when elective admissions cannot be accommodated due to a high census or operational difficulties. When a determination is made that a patient could be safely discharged to accommodate a pending admission, the patient will be discharged, with the consent of the attending physician, unless they are unavailable. In that case the chairman of the appropriate department shall be consulted for discharge.

1.6 ADMISSION OF NEWBORNS BORN IN AND OUT OF THE HOSPITAL

1.6-1 BABIES BORN IN THE HOSPITAL

- Babies born within the building are considered Hospital births, although the birth may not have occurred in the delivery room or on the single room maternity nursing unit.

- Babies not born in the delivery room or single room maternity-nursing unit are admitted to the normal newborn nursery or the Special Care Nursery, as appropriate.

- Mothers are admitted to the maternity floor. If requested and appropriate, the baby may share the same room as the mother.

- Babies are registered as a newborn admission and assigned a separate financial number. The registrar prepares an admission chart and a patient's signature is obtained on the general admission consent form.

- Also see Newborn Nursery, Infection Control Policies

1.6-2 OTHER APPLICABLE POLICIES

Other policies as outlined in the Department of Nursing, policy on care of newborns delivered outside of the labor and delivery area to be followed.

1.7 OBSERVATION STATUS

1.7-1 PURPOSE

The purpose of observation status is to provide skilled services for short-term diagnostic and therapeutic intervention of short duration, high intensity services and to observe a patient to determine the medical necessity for admission to the hospital as an inpatient. Hospital Policy must be followed.

1.8 RESTRICTED BED USE AREAS

Areas of restricted bed utilization and assignment for patients are as follows:

- ICU - Intensive Care Unit
- SCN - Special Care Nursery
- IMC - Intermediate Medical Care (Saints Campus)
- PCU - Progressive Care Unit
- L&D - Labor & Delivery
- D4 - Cardiovascular Unit

Questions regarding the appropriateness of admission to or discharge from any of the above areas shall be referred to the physician director of the unit, or their designee. Any dispute between the attending physician and the Medical Director of the unit or the designee, will be referred to the appropriate Department Chief(s). For more information regarding unit scopes of service, please refer to the Lowell General WIRE.

1.9 ADMISSION INFORMATION

1.9-1 A patient shall not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. Other required documentation or information specific to the type of admission

involved is detailed in Part 1.3.

1.9-2 The admitting practitioner shall be responsible for providing the following information concerning a patient to be admitted: any source of communicable or significant infection, behavioral characteristics that would disturb or endanger others; and need for protecting the patient from self-harm. Physicians admitting patients shall be held responsible for giving information, unless precluded by statute, as may be necessary to assure protection of other patients from those who are a source of danger from any cause whatsoever or to assure protection of the patient from self-harm.

1.10 ADMISSION OF PERSONS INCAPACITATED BY ALCOHOL/DRUGS

The hospital shall allow admission for the emergency observation, evaluation, and treatment, of persons incapacitated through the use or misuse of alcohol or drugs.

PART TWO: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 ASSIGNMENT TO SERVICE

All patients are assigned to the Service concerned with the treatment of the problem or disease that necessitated admission.

2.2 ATTENDANCE OF PATIENTS

2.2-1 REQUIREMENT OF AN ATTENDING PHYSICIAN

The practitioner of their choice shall attend each patient admitted to the hospital, provided said practitioner is a member of the medical staff, has appropriate clinical privileges, and accepts the patient for admission. In other events, patients requiring admission shall be assigned to an acceptable physician pursuant to Part 1.2-5 of these Rules.

2.2-2 IMMEDIATE VICINITY REQUIREMENTS

All members of the medical staff are encouraged to be in the vicinity that promotes their availability for prompt evaluation of their patients in the event of an emergency. Those who do not shall prospectively designate a member of the medical staff that agrees to take the responsibility to attend their patients in an emergency and shall notify the patient's attending nurse of this transfer of responsibility.

2.3 PARTICIPATION IN THE ER ON-CALL WARD SERVICE ROSTER

2.3-1 GENERAL REQUIREMENTS

Unless specifically exempted by the Medical Executive Committee and the Chief Medical Officer or their designee, for good cause shown, each member of the active staff agrees that, when they are the designated practitioner on the ER On Call/Ward Service Roster, they will accept responsibility during the time specified by the published schedule for providing care to any patient, who does not have an established physician-patient relationship with a provider in that specialty, in any unit of the Hospital referred to the specialty for which they are providing on-call coverage.

The on-call physician is responsible for the care of the patient they admit until the patient's personal physician or designated coverage person assumes responsibility.

2.3-2 EXEMPTIONS

Exemptions for participation in the on call roster shall be approved by the Medical Executive Committee. Possible exemption requests may be based upon:

- Membership in non-clinical specialties
- Poor health as determined by and at the discretion of the Medical Executive Committee

Any and all exemptions granted by the Medical Executive Committee may be rescinded at any time based upon hospital/departmental need and/or changes in the status of the exempted practitioner.

The assignment of ER On Call/Ward Service to a provider of any specialty does not negate other physicians in that specialty from providing assistance when needed.

2.3-3 ON-CALL SCHEDULING

Scheduling is the responsibility of the appropriate department chief. Any changes are the responsibility of the individual physician. The Medical Staff Office shall be notified of all such agreed upon changes.

2.4 EMERGENCY DEPARTMENT ON-CALL COVERAGE

2.4-1 PHYSICIAN SPECIALIST COVERAGE OF THE EMERGENCY DEPARTMENT

- There shall be a physician on call to the Emergency Department for each major clinical service or specialty provided by the Hospital. The Chief of each Department shall designate which physicians in their department shall take call for that service or specialty.
- On call physicians shall be able to arrive and shall arrive within a timeframe as determined by the Chief of Service, after being summoned for a critical case under normal transportation conditions.
- The Medical Staff Office will, under the direction of each department Chief, prepare a monthly on-call list by specialty and forward a copy to the Emergency Department prior to the beginning of each month.
- The current list of on-call physicians shall be conspicuously posted in the Emergency Department at all times.
- All specialties on the active medical staff will be included in the on-call list.

- The Emergency Department physician will call an appropriate on-call specialist when it is determined that a specialist is needed to rule out emergency medical conditions, help stabilize a patient, or provide the definitive care necessary for the stabilization of the patient.

- A physician properly designated as being on-call for the Emergency Room that does not respond as outlined in these Rules and Regulations shall be deemed non-compliant for that event and subject to reporting to the CMO, and disciplined by the Chief of the appropriate department. A physician with repeat offenses will be reported to the Medical Executive Committee.

- The Emergency Department Medical Director or designee will monitor compliance with the provisions of Part 2.4-1 of these Rules on an on-going basis. Non-compliance will be referred to the CMO for investigation. The CMO's findings and recommendations will be forwarded to the appropriate department Chief for follow-up and corrective action.

- When an on-call physician is unavailable because of other clinical responsibilities, alternative arrangements include: 1) notification of a partner or otherwise noted covering physician, 2) notification of an alternative group or physician with different coverage, or 3) referral to an alternative site for care. In all cases appropriate care and compliance with EMTALA regulations will apply.

PART THREE: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERAL REQUIREMENTS

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of those portions of the medical record for which they are responsible, for necessary special instructions, and for transmitting such instructions, if any, to the patient and to his or her caregiver. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is effected pursuant to Section 3.2.

- All patients will receive the same quality of patient care by all individuals with delineated clinical privileges, within medical staff departments, across departments/services, and between members and nonmembers of the medical staff who have delineated clinical privileges.

- When acting in the capacity of supervisor of practitioners in training, the medical staff member shall be responsible for assuring that these delegated responsibilities are performed in an adequate and timely manner when applicable and in accordance with these Rules and Regulations and Hospital policy.

3.2 TRANSFER OF RESPONSIBILITY

3.2-1 When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, a note covering the transfer of responsibility and acceptance of the same shall be entered on the order sheet and progress notes by the admitting or attending physician. Patients may be transferred to the service (responsibility) of another physician only when the physician receiving the patient in transfer acknowledges and agrees to the transfer by written or verbal acknowledgment as documented above.

3.2-2 All patients requiring surgery shall be transferred to the attending surgeon at the time of surgery.

3.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate, professional care for their patients in the Hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient.

3.4 ALLIED HEALTH PROFESSIONALS (MEDICAL ANCILLARY STAFF)

3.4-1 The services of certain allied health professionals, which are necessary and proper to the hospital function and treatments therein, may be available within the limits of their technical skills and the scope of their lawful practice. The Medical Ancillary staff shall not admit patients directly. They shall participate in the care of patients only under the supervision of a physician on the Active Medical Staff.

3.4-2 All applicants to the Medical Ancillary Staff (Allied Health Professionals) must conform to the same procedures that are used to process the applications of physicians seeking staff privileges pursuant to the Medical Staff Bylaws. Documentation of education and licensure by the Commonwealth of Massachusetts must be submitted. Every Medical Ancillary Staff shall carry out his/her activities subject to hospital policies and procedures and in conformity with the applicable provisions of the Medical Staff Bylaws and these Rules and Regulations.

3.4-3 Job descriptions, duties, qualifications, and responsibilities of a given Allied Health Professional shall be defined by the department responsible for the supervision of that individual.

3.4-4 Allied Health Professionals Staff may include but not limited to:

- Assistant to Physician/Dentist
- Certified Registered Nurse Anesthetist
- Certified Nurse Midwife
- Operating Room Technician
- Perfusionists (Cardiac Surgery)
- Psychologists
- Sports Surgery Technologists
- Nurse Practitioners
- Physician Assistants
- Neuropsychologists

3.4-5 Allied Health Professional Staff may treat patients under the conditions provided in the Medical Staff Bylaws and in these Rules and Regulations. An Allied Health

Professional is responsible for documenting in the medical record, at the time of service, a complete and accurate description of the services they provide to the patient.

3.5 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the individual's supervisor who, in turn, may refer the matter to the attention of the appropriate Department Chief or the CMO. The Department Chief or the CMO shall discuss this concern with the attending physician. As delineated in 3.6-1, the CMO may order consultations if indicated in the best interest of the patient, the medical staff, and the hospital. For further reference refer to Policy – Patient Care Conflict Resolution Process Policy in Patient Rights Book

3.6 CONSULTATIONS

3.6-1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultations. The attending practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated or required pursuant to the guidelines in Part 3.6-2 below or at the request of the patient and/or family members if deemed appropriate by the attending physician. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner. The CMO, on his own motion or on the request of the Chief Executive Officer or their designee, may order consultations or additional consultations if they so deem indicated in the best interest of the patient, medical staff, or the hospital. It is the duty of the hospital staff, through each Department Chair, the CMO, and the Medical Executive Committee, to make certain that members of the staff do not fail in the matter of requesting consultations as needed.

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the CMO, the physician director of a special unit, or the Chief of the Department. If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the CMO for final decision and direction.

All orders mandated by consultants shall be followed. Any dispute between the attending physician and the consultant shall be settled by the Chief of the Department of the attending physician's service.

3.6-2 QUALIFICATIONS OF CONSULTANT

Any qualified practitioner may be called as a consultant regardless of his staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or sub-specialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and has been granted the appropriate level of clinical privileges.

A practitioner who requests consultation by a practitioner not on the staff of the Hospital must make such requests to the Department Chief, who will confer with the CMO, before consent is granted. Such consultants may be granted temporary consulting privileges in accordance with the Medical Staff Bylaws.

3.6-3 RULES REGARDING CONSULTATIONS

- **CONSULTATION REQUEST:**
  - When a practitioner who has already evaluated the patient in the hospital determines that an outpatient consult is warranted in lieu of an evaluation at the hospital, then the patient can be referred to the physician they have an established relationship with in that specialty. If there is not an established physician relationship within the specialty, the patient will be referred to the on-call consultant physician for effective follow-up. Such referral may take one of two forms:
    - Direct discussion with the consultant, with documentation of the conversation in the patient's chart and with transmission of patient discharge/referral documentation to the consultant's office. The chart documentation will clearly identify the nature of the referral and the name of the consultant.
    - Transmission of patient discharge/referral documentation to the consultant's office without direct discussion (when deemed appropriate by the attending practitioner or Emergency Department practitioner). The chart documentation will clearly identify the nature of the referral and the name of the consultant. The requesting practitioner is responsible for assuring that the consultant has received the referral. The consultant is responsible for acting on the referral as per the consultant's individual protocol.

- When a practitioner contacts a consultant for advice regarding a specific patient, that interaction will be documented in the chart and will include the requesting practitioner's name and the consultant's name. Additional action will be determined by the requesting practitioner and the consultant.

- Requests for interpretation of tests will not constitute a consultation. Documentation in the chart must specifically indicate that "interpretation only" was requested. The requesting practitioner and interpreting provider will be documented in the chart.

- If the consult is urgent, the requesting physician shall contact the consultant or physician covering for him or her to describe the nature of the consultation request. If a consultant cannot be reached, the attending physician shall be notified and shall be responsible for designating an alternative consultant. They will document that the communication was made that it was urgent.

- If the consult is routine, the nurse or unit secretary will notify the physician, physician's office or service, and document notification on the medical record.

- The attending physician is responsible for the care of the patient unless and until there is a formal change in service to the consultant. The change of service shall not occur until the consultant sees the patient, accepts the patient in transfer and the patient concurs with the decision.

- The consult covers those areas specified by the attending. This decision is agreed upon between the primary physician and the consult.

- When both a consultant and attending physician are involved in a case, the attending physician should be contacted about changes in condition and general care by the consultant. Questions about an order or results of a test shall be reported to the physician who wrote the order.

- It is the expectation that urgent consults will be responded to by the consultant at a time mutually agreeable between the requesting physician and the consultant, usually within 4 hours. Likewise routine consults will be responded to within a time frame suitable to the clinical situation and at a time mutually agreeable between the requesting physician and the consultant, usually within 24 hours.

- All members of the medical staff are urged to engage in verbal contact with their consultants and (vice versa) as it is recognized that such

communication enhances patient care and satisfies the requirements of high-level professional etiquette.

3.6-4 PEDIATRIC / FAMILY PRACTICE CONSULTATIONS/CASE MANAGEMENT BY A PEDIATRIC PROVIDER

Any child under the age of fifteen years who is admitted to the adult intensive care unit must have a pediatric provider consult or case management by a pediatrician.

3.6-5 DOCUMENTATION

- **CONSULTATION REPORT:**

  The consultant must make, date and sign a report of his findings, opinions and recommendations that reflects an interview with the patient, an examination of the patient, and a review of the medical record, including the review of laboratory data, which supports his opinion and recommendation for treatment. When operative procedures are involved, the consultation notes, except in emergencies, shall be recorded prior to the operation. Such reports shall be made upon the EHR forms designated for this purpose, at the time of consultation, and shall be incorporated into and be made a part of the patient's medical record

PART FOUR: TRANSFER OF PATIENTS

4.1 INTERNAL TRANSFER

4.1-1 TRANSFER PRIORITIES

Internal patient transfer priorities are as follows:

1. Emergency patient to an available and appropriate patient bed
2. From Critical Care Unit to any general or intermediate care room
3. From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient

4.1-2 GENERAL REQUIREMENTS

- No patient will be transferred without such transfer being approved by the practitioner responsible for the patient except in the case of transfers from the Special Care Units to the general care area. Selection of such patients for transfer is the responsibility of the attending in charge of the Special Care Unit who must also inform the attending directly responsible for the care of the patient.
- With the exception of emergencies, transfers from one service to another shall be done by written or verbal consent of both practitioners (i.e., the practitioner of the section to which the patient should be transferred). This written consent of both parties shall be documented in the medical record.

4.2 TRANSFER TO ANOTHER FACILITY

4.2-1 GENERAL REQUIREMENTS

A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient. The transfer documentation in the medical record must include a statement by the attending physician that, in his/her judgment, such transfer will not create a medical hazard to the patient or that such transfer is considered to be in the patient's best interest despite the potential hazard to movement. Such transfer shall be made only after explaining the need for it to the patient and to the patient's family or significant other.

4.2-2 SPECIFIC REQUIREMENTS

- The decision to transfer a patient to another facility shall be in the patient's best interest, comply with all Federal and State Rules and Regulations, and agreeable to the patient and the accepting facility. Documentation of such shall be in the medical record.

- Prior to an anticipated transfer, the patient will receive a medical examination to determine whether he/she has an emergency medical condition or is in active labor. For the purposes of this Rule, an emergency medical condition is one of such acuity or severity that there is a reasonable likelihood of its placing the patient's health or life in jeopardy or producing serious impairment of bodily functions, body organs or parts. If any of these conditions are found to be present, the practitioner will provide such further examination and treatment as is necessary to stabilize the condition, or to effect a safe and appropriate transfer.

- The treating Hospital physician or medical department chief or designee will contact the appropriate physician at the receiving facility who is authorized to accept the patient transfer. The transferring physician will review the patient's clinical findings, treatment, and needs with the receiving physician.

- The receiving physician must formally accept responsibility for the patient in transfer and this must be documented on the patient's medical record. The receiving physician will make any needed admission arrangements in the receiving facility.

- The receiving and referring physician will agree on the medical details of transport. The Hospital will provide all needed medical resources during transport unless other arrangements have been agreed upon between the physicians.

- Medical responsibility for the patient's care remains with the referring physician until arrival at the receiving facility or care is transferred to a physician member of the transport team.

- Copies of all relevant treatment records, including lab results, X-rays EKG's, consultation reports, etc., will accompany the patient.

4.2-3 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

- A transfer demanded by an emergency or critically ill patient or his family or significant other is not permitted until a physician has explained to the

patient or his family or significant other the seriousness of the condition and not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign release, a completed form without the patient's signature and a note-indicating refusal must be included in the patient's medical record.

- A physician order is necessary for the transfer/discharge of a critically ill patient to another facility.

4.2-4 TRANSFER OF HIGH RISK OBSTETRICAL PATIENTS

- All high-risk patients must be seen by the primary physician and evaluated before being transferred to an alternative facility.
- The Outpatient Authorization for Transfer form must be completed and signed by the physician prior to transfer.
- All patients are to be stabilized prior to transport. Specifically, the patient should have IV access in place, a reassuring fetal heart monitoring strip, and stable vital signs.
- When possible, the mother should be referred or transported prior to delivery to the service level warranted by her condition and the anticipated condition of her infant.
- Maternal transfer should be considered for the specific conditions delineated in hospital policy "The Management of the Obstetric Patient Requiring Transport."
- All such transfers shall be in compliance and pursuant to the Hospital's policy "The Management of the Obstetric Patient Requiring Transport." See Hospital Policy, The Management of the Obstetric Patient Requiring Transport, Attachment B.

4.3 INTER-FACILITY TRANSFERS FOR SPECIALIZED TREATMENT

4.3-1 This rule relates to transfers into the Hospital for special treatment not provided by referring hospitals.

4.3-2 The request for transfer will be made to the Admitting Office. Admitting will obtain financial information from the referring hospital and obtain pre-certification, if needed.

4.3-3 Urgent and emergent admissions will be accepted and pre-certification will be

obtained within 24 hours. If applicable, the referring hospital will send Lowell General Hospital copies of their charity care applications and documentation.

4.3-4 If the required treatment/procedure can be done as an outpatient, the patient will be registered as an outpatient and returned to the referring hospital following the treatment/procedure.

4.3-5 Patients transferred to Lowell General Hospital should arrive on the day of the scheduled procedure. However, should the patient need to be transferred prior to the day of the procedure, they must be cleared through the Case Management staff.

4.4 TRANSFERS FROM ANOTHER FACILITY

The Hospital may accept transfers from other facilities provided the patient is eligible for admission and that beds are available. The transferring facility must ensure that the patient is sufficiently stabilized for transfer and must also assume responsibility for the patient during transfer. All pertinent medical information must also accompany the patient.

PART FIVE: DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

5.1-1 GENERAL REQUIREMENTS

- A patient shall be discharged only on the order of the attending physician or their designated Allied Health Professional. The attending physician is responsible for documenting the principal diagnosis, secondary diagnoses, co-morbidities, complications, principal procedures, and additional procedures on the clinical resume, discharge summary, or final progress note. (See Section 7.6-1 of these Rules.)

- 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.

- The discharge order shall be entered and authenticated in the medical record.

- Transfer documentation, if applicable, must be complete prior to the patient's discharge so that it can accompany the patient.

- Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

5.2 LEAVING AGAINST MEDICAL ADVICE

5.2-1 If a patient desires to leave the Hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, the attending physician must record the incident in the patient's medical record.

5.2-2 After notifying the attending, the patient will be requested to sign the proper release. This must be dated and witnessed. If the patient refuses to sign the

release, this fact shall be recorded on the Nursing Notes. An incident report describing the circumstances shall be completed. The patient may then leave the Hospital.

5.2-3 The above steps must be documented on the Nursing Notes.

5.2-4 If it is discovered that the patient has left the Hospital premises without informing the Hospital personnel, Security, Nursing Services, and the attending physician shall be notified. The circumstances shall be documented in the patient's medical record and an incident report shall be filled out and processed.

5.3 DISCHARGE OF MINOR PATIENTS

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

5.4 DISCHARGE PLANNING

5.4-1 GENERAL REQUIREMENTS

Discharge planning shall be initiated for all patients according to the individual patient's need on admission to the Hospital and as early as a determination of need can be made. Discharge planning shall involve all departments/services as described in the Hospital's Utilization Management Plan. Discharge planning should provide for continuity of care to meet the patient's needs. These plans should be documented in the medical record. Criteria for discharge must include the availability of appropriate services to meet the patient's needs. Also see Hospital's Policy "Discharge Information."

PART SIX. ORDERS

6.1 GENERAL REQUIREMENTS

6.1-1 ORDERS:
All orders shall be entered into the computer system by a physician or licensed independent practitioner, or their designated approved representative. All orders shall be dated and timed and contain all required elements of information, such as dose, frequency, route for medication orders, so that the person carrying out the order has a complete understanding of the order. Written orders will be accepted during scheduled or unscheduled computer down time or when a patient is sent from an outside office or clinic for admission or testing and use of CPOE from the outpatient setting is impossible or impractical. All written orders must be dated, timed and signed.

6.1-2 Authorized individuals include the following individuals: physicians, pharmacists, nurse practitioners, physician assistants, Certified Nurse Midwives, CRNA's, respiratory therapists, physical therapists, occupational therapists, dietitians, x-ray technicians, and certified and registered laboratory staff as appropriate for their fields. Section 6.5 delineates what limitations exist for these authorized individuals.

6.1-3 Orders entered into the medical record may be accepted from all medical staff members, house staff and other authorized individuals within the scope of their practice privileges.

6.1-4 When a House Staff member, Nurse Practitioner, or Physician Assistant enters orders on a patient, these orders must be countersigned by the attending physician, podiatrist, or dentist, in accordance with department specific practice guidelines. Care rendered by a nurse practitioner or physician assistant in an inpatient setting must be reviewed daily and all inpatient orders must be co-signed by the supervising practitioner or their designee within 24 hours. Care rendered by a nurse practitioner or physician assistant in the outpatient setting may be reviewed and co-signed at the end of an episode of care. Care rendered by a Certified Nurse Midwife may be reviewed and co-signed at the end of an episode of care by the collaborating physician.

6.2 PROTOCOL ORDERS

6.2-1 Protocol orders shall be defined as a predetermined protocol of physician orders. Protocol orders may be formulated by appropriate committees or departments, but must be approved by the Medical Executive Committee and the Chief Medical Officer or his designee. They can be changed only by mutual consent of the

Medical Staff and the Chief Executive Officer or his designee, and the latter shall be responsible for notifying affected personnel. The attending physician for each individual patient shall co-sign these orders. The Medical Executive Committee will review Protocol Orders concurrently as submitted for consideration by members of the medical staff or medical staff committees.

6.2-2 All Protocol orders will be implemented unless removed or discontinued by the ordering practitioner.

6.2-3 Physician Protocol Orders may be implemented in the absence of physician's co-signature within the specified time limits for all patients admitted to the critical care/specialty units.

- In the event of an emergency, protocol orders for the appropriate critical care unit will be implemented until the arrival of a physician for those patients not previously covered by protocol orders.
- If a Cardiac Emergency Certified (ACLS Certified) nurse responds to a Code 99 outside of the critical care units, emergency resuscitative measures will be implemented in accordance with critical care standing orders.

6.2-4 To expedite the care of obstetrical patients and their newborn infants, protocol orders will be followed.

- A copy of the protocol orders for each obstetrical patient and their newborn will become a part of each patient's/newborn's record.
- The physician pursuant to these Rules must countersign all protocol orders.

6.2-5 A practitioner's protocol orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's medical record, dated, and co-signed by the practitioner.

6.3 COMMUNICATION ORDERS

Communication orders are available to allow providers to give nurses or ancillary personnel instructions on aspects of patient care not contained within a standard order set. (i.e. "call physician with results of Head CT"). Free test communication orders may not be used to order anything found elsewhere within the order catalog. This includes but is not limited to medication, IVs, transfusion, lab, diets, and diagnostic tests. The only exception shall be communication orders that are pre-built within an order set or built as an approved single order.

6.4 VERBAL ORDERS

Verbal orders shall be utilized only when necessary to meet the care needs of the

patient when it is impossible or impractical for the prescriber to enter the order into the computer system including orders given during emergency or code situations or when the provider is scrubbed for a surgery or procedure. Admission orders, medication orders, and orders that would constitute high-risk processes, such as blood administration, are generally not accepted as verbal orders except for life threatening emergency, intraoperative hemorrhaging. Telephone orders are accepted only when the provider is not present in the hospital. Verbal and telephone orders may be entered into the CPOE system by appropriate Hospital personnel, i.e. registered nurse, pharmacist, or respiratory therapist). Verbal and telephone orders shall be verified by read-back to the ordering provider including the reading of any alerts generated by the computer. Verbal and telephone orders shall be countersigned by a physician within forty-eight (48) hours.

6.5 TELEPHONE ORDERS

6.5-1 DOCUMENTATION

All telephone orders shall be entered by the individual taking the order and co-signed, dated and timed by the prescribing practitioner or another practitioner responsible for the care of a patient, even if the order did not originate with that practitioner within 48 hours. Telephone orders shall be accepted by qualified personnel (R.N.s) or other authorized personnel if the order is within their professional field as identified in Part 6.1-2 of these Rules and Regulations and as specifically delineated below, with the following restrictions where noted:

1 A physician, dentist, or podiatrist with clinical privileges at this Hospital

2 A registered nurse

3 A licensed practical nurse may transcribe all orders except telephone orders for medication that they are not allowed to administer.

4 A pharmacist who may transcribe telephone orders pertaining only to medications

5 A Physical Therapist, Occupational Therapist, Speech Therapist, and Recreational Therapist may transcribe telephone orders pertaining only to their respective disciplines.

6 A Dietician may transcribe telephone orders pertaining only to dietary orders.

7 A Respiratory Therapist may transcribe telephone orders pertaining only to respiratory therapy treatments.

8. A Radiologic Technologist may transcribe telephone orders pertaining only to diagnostic testing.

9. All medication telephone orders require a read back of the complete order by the receiving person including any electronic alerts. The receiving person must write, read, and verify

with the date.

All telephone orders shall be entered in the medical record and shall include the date, time, name and signature of the person transcribing the order and the name of the practitioner and shall be co-signed by the prescribing practitioner.

6.6 AUTOMATIC CANCELLATION OF ORDERS

Orders for medications are automatically discontinued when patients are transferred to or from an Intensive Care Unit, transferred from the Special Care Nursery to the Newborn Nursery or Pediatrics, sent to the Operating Room or Delivery Room.

6.7 STOP ORDERS

6.7-1 DRUGS/TREATMENTS COVERED AND MAXIMUM DURATION

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified.

When that has not been done, a stop order will be placed automatically, as specified in section 6.7-2 that indicates the schedule for the rewriting of orders. In implementing the stop order, nursing/pharmacy/respiratory therapy will calculate the maximum duration permissible so as to cover the total number of hours indicated. In no event shall the drug or treatment be given for the maximum duration permissible if the last effective order specifies a shorter interval or particular dosage.

6-7.2 PARAMETERS FOR AUTOMATIC STOP ORDERS

Certain medications will automatically be discontinued according to the guidelines listed below:

Controlled Substance Infusions	24 Hours
Epidurals	24 Hours
PCA	24 Hours
Neuromuscular Blocking Agents	24 Hours
TPN	24 Hours
All high risk IV drips (e.g. Mag sulfate for eclampsia, dopamine, neosynephrine)	24 Hours
Anticoagulants – IV Infusions.	3 Days
IV fluids	24 Hours
Low Molecular Weight Heparin (e.g. Fragmin) Fondaparinux and Heparin Subcutaneous	5 Days

Ketorolac (Toradol) IV or PO	5 Days
Anti-Infective (excluding topicals)	5 Days
Controlled Drugs (Schedule II) *Exception – Meperidine	7 Days 2 Days
Controlled Drugs (Schedule III-V)	14 Days
PRN Psycho-actives & Anxiolytics	14 Days

6.7-3 EXCEPTIONS

Exceptions to the stop order rule are made under the following conditions:

- The last effective order indicated an exact number of doses to be administered;
- The last effective order specifies an exact period of time for the medication; or
- The prescribing practitioner reorders the medication or treatment.

6.7-4 NOTIFICATION OF STOP

The applicable unit (nursing/pharmacy/respiratory therapy) shall notify the prescribing practitioner within 12-36 hours on the written clinical record before an order is automatically stopped. A notification of stop will be sent to the ordering provider via the physicians' electronic medical record inbox.

6.8 BLOOD/BLOOD PRODUCTS TRANSFUSIONS AND INTRAVENOUS INFUSIONS

6.8-1 STARTING

Blood transfusions and intravenous infusions must be started by the attending practitioner, a physician assistant with requisite privileges, or by a registered nurse that has the requisite training. The order must specifically state the blood product, blood component, or IV solution and must state the rate of infusion. All I.V. orders should be written completely, with the solution desired and if any additives are ordered.

6.8-2 NEED FOR INFORMED CONSENT FOR BLOOD/BLOOD PRODUCTS TRANSFUSIONS

The practitioner must clearly explain to the patient and document in the medical record the potential risks and benefits of blood transfusions and alternatives available to the patient and, when appropriate, the family.

More specifically, the explanation shall include the following:

- potential benefits and risks;
- the possible results of not having a blood transfusion; and
- any significant alternatives.

6.8-3 AUTOLOGOUS BLOOD

The patient may consult with their physician to determine whether or not autologous donation would be beneficial for their surgery.

PART SEVEN: MEDICAL RECORDS

7.1 UNIT RECORD SYSTEM

7.1-1 SCOPE OF MEDICAL RECORD DOCUMENTATION

- A medical record shall be properly maintained and documented for all patients registered, assessed, and/or receiving treatment at the Hospital.

7.1-2 UNIT RECORD

A unit record shall be maintained for all inpatient, same day surgery, observation and Emergency Department patients. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. The physician's responsibility shall include an admission history and physical examination, an admitting note on emergency or urgent admissions, progress notes, operative reports, when indicated, and a discharge summary.

7.1-3 AUTHORIZED ENTRIES

- Authorized individuals who make entries into the medical record are limited to Members in good standing of the Medical Staff as outlined in the Bylaws, employees of Lowell General Hospital involved in patient care, and other authorized personnel and students of training programs having direct patient care contracted with and/or sponsored by Lowell General Hospital

- The record's content shall meet legibility, timeliness, and professional standards as outlined in the Medical Staff Bylaws, Rules and Regulations, and Policy and Procedures and as outlined by federal, state, and local statutes. The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results and promote continuity of care among health providers.

7.1-4 REQUIRED CONTENT

The Medical Record shall contain all of the following information:

a. The patient's name, address, date of birth, and the name of any legally authorized representative;
b. The legal status of patients receiving mental health services;

c. Emergency care provided to the patient prior to arrival, if any;

d. The record and findings of the patient's assessment;

e. Conclusions or impressions drawn from the medical history and physical examination;

f. The diagnosis or diagnostic impression;

g. The reasons for admission or treatment;

h. The goals of treatment and the treatment plan;

i. Evidence of known advance directives;

j. Evidence of informed consent, when required by hospital policy;

k. Diagnostic and therapeutic orders, if any;

l. All diagnostic and therapeutic procedures and test results;

m. Test results relevant to the management of the patient's condition;

n. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
After all surgery, an operative progress note shall be generated. It shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, apparent complications, and postoperative diagnosis.

A comprehensive operative report shall be dictated or generated immediately after surgery. It shall include the name of the primary surgeon and assistants, procedure performed and a description of each procedure finding, estimated blood loss, specimens removed and postoperative diagnosis. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a brief op note is entered immediately.

o. Daily Progress notes made by the medical staff and other authorized individuals;

The attending physician or his designee shall generate a progress note at least daily. These shall include clinical observations, clinical diagnoses as they evolve, results of therapy and the patient's response to care. They shall communicate the process of informed consent for all care advised and/or rendered, including what was communicated and what the patient or legal representative understood and responded to. Other Medical Staff members shall likewise document their patient encounters in progress notes immediately after these services are performed.

p. All reassessments and any revisions of the treatment plan;

q. Clinical observations;

r. The patient's response to care;

s. Consultation reports;

t. Every medication ordered or prescribed for an inpatient;

u. Every medication dispensed to an ambulatory patient or an inpatient on discharge;

v. Every dose of medication administered and any adverse drug reaction;

w. All relevant diagnoses established during the course of care;

x. Any referrals and communications made to external or internal care providers and to community agencies;

y. Conclusions at termination of hospitalization;

z. Discharge instructions to the patient and family;

aa. Facesheet

The Facesheet (patient identification data) shall include the patient's name, address, date of birth, age, sex, origin, next of kin or contact in case of emergency, financial information, billing and medical record number and the name of any legally authorized representative. When this information is unobtainable, the reason shall be documented in the medical record.

bb. Clinical Resumes, Discharge Summaries, Final Progress Note, or Transfer Summary

Upon discharge, the clinical résumés, discharge summaries, or a final progress note or transfer summary shall include the principal diagnosis, other diagnoses, complications, co-morbidities, and procedures performed using terminology originated by The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services and definitions for principal and secondary diagnoses as defined in the Uniform Health Services Discharge Data Set. There shall be no abbreviations of these diagnoses and procedures. In circumstances where pending laboratory or other data prevents accurate assignment of a principal or secondary diagnosis; the discharging physician may defer their assignment by stating "Pending results of tests". The discharging or attending physician shall assign these diagnoses once these test results are available, but no longer than 30 days after discharge. The physician shall have the option to amend his diagnoses upon query by appropriate personnel by documenting such as an addendum to the medical record.

The history and physical examination shall be comprehensive and compliant with reasonable standards required of professional organizations, regulatory agencies, and payers. It shall include all pertinent findings resulting from an assessment of all the systems of the body and include the chief complaint, history of present illness, past history, family history, social history, system review, physical examination by body systems, admitting diagnoses, and a statement of course of action.

A short form history and physical may be used for observation patients and same-day surgery patient, however it must reflect the performance of a comprehensive evaluation as described above.

For obstetrical patients, a comprehensive prenatal office record can augment the

information of the History and Physical, but does not replace the History and Physical.

7.1-5 USE OF ENGLISH LANGUAGE

All entries in the Medical Record shall be made in clear, understandable English.

7.1-6 DELINQUENT MEDICAL RECORDS

Medical records shall be completed within thirty days after discharge. If not complete within thirty days the record will be considered delinquent. A record will also be considered delinquent if a history and physical is not performed and on the chart within twenty-fours, if a brief summary operative not is not written in the chart immediately after surgery and if a comprehensive operative report is not dictated within 24 hours of the surgery. The record will also be delinquent if all other clinical reports such as the Emergency Department record, consultative reports, all orders, a final progress note and a discharge summary are not complete within thirty days of discharge.

Delinquent record counts shall be done weekly under the Director of Health Information Management. A list of physicians not having completed their portion of the medical record will be forwarded weekly to the Chairman of each department and to the CMO.

Any physician with a delinquent record will be notified of the deficiency and will have seven days to complete the record. If the record is not completed within these seven days the physician will be notified in writing, by return receipt mail that he or she has another seven days to complete the record or face suspension. The physician, CMO, chairman of the department and admitting office will be notified of the suspension. It will be the responsibility of the suspended physician to provide interim coverage for his or her patients and if he or she does not do so it will be the responsibility of the CMO or his designee to assign coverage.

A list of suspended physicians will be provided on a monthly basis to the President of the Medical Staff and the Medical Executive Committee. If completion of records does not occur within seven days the offending physician may face further disciplinary action by the Medical Executive Committee.

Extenuating circumstances of illness, prolonged vacation or other absence from the community must be explained in writing to the CMO and may result in a continuation of privileges if deemed appropriate.

7.2 HISTORY AND PHYSICAL EXAMINATION

7.2-1 GENERALLY

A complete history and physical examination shall be generated in the medical record or dictated within 24 hours after admission of the patient. If dictated, the medical record must contain an admission note within 24 hours that provides pertinent findings from the history and physical examination. The attending practitioner must generate an admission note also within 24 hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. The history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a documented review of all systems.

Delegation is limited to the physician's assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of a LIP to be performed by a non-LIP the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

If it is determined that state law and regulation and professional practice acts allow delegation of the LIP history and physical examination, the exam can be delegated, provided:

- the medical staff and the organization have appropriate policies and procedures
- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- the non-licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the non-licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by medical staff bylaws, rules and regulations and policies and procedures
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns, dates and retains accountability for the patient's medical history and physical examination.
- the person is specifically permitted by the organization to perform the history and physical either,
- as part of the supervising/delegating physician's privileges, or
- through an specific alternate process, such as that utilized by the organization for allied health practitioners

7.3 PREOPERATIVE DOCUMENTATION

7.3-1 HISTORY AND PHYSICAL EXAMINATION

A relevant history and physical examination is required on each in-patient and outpatient receiving conscious sedation or anesthesia other than local anesthesia. Except in an emergency, so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the medical record.

If the history and physical examination have been dictated but are not on the medical record at the time of surgery, an electronic entry must be placed before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, the anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) shall not administer anesthesia and shall not allow the surgery to proceed. In case of an emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with applicable sections of the Medical Staff Bylaws.

If it is determined that state law and regulation and professional practice acts allow delegation of the LIP history and physical examination, the exam can be delegated, provided:

- the medical staff and the organization have appropriate policies and procedures
- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the -licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by medical staff bylaws, rules and regulations and policies and procedures
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns and retains accountability for the patient's medical history and physical examination.
- the person is specifically permitted by the organization to perform the history and physical either,
- Cannot exceed their supervising physician's privileges ---as part of the supervising/delegating physician's privileges, or
- through an specific alternate process, such as that utilized by the organization for allied health practitioners

This delegation is limited to the physician's assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of a LIP to be performed by a non-LIP the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

A History and Physical which is performed up to or no more than 30 days before admission may be utilized provided it is updated to reflect the patient's status at the time of admission but prior to surgery. It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record augments, but does not replace the history and physical, which should document any and all diagnoses, an up to date exam, and any care beyond the normal labor care.

7.3-2 SHORT FORM

The Short Form History and Physical Examination, the template for which is present in the EHR, may be utilized for patients having a length of stay within 48 (forty-eight) hours. A short form history and physical examination may be utilized for Same Day Surgery patients. The short form shall contain all the elements required of a comprehensive history and physical examination and informed consent as described in the bylaws and Rules and Regulations.

7.3-3 30 DAYS BEFORE ADMISSION

If a history and physical examination have been performed within 30 days before admission, a durable copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission. An addendum must be made even if there are no changes stating such.

7.4 PROGRESS NOTES

7.4-1 GENERAL REQUIREMENTS

- Pertinent progress notes must be generated at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner.

- Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and must be correlated with specific orders as well

as the results of tests and treatment.

- Progress notes shall be in a format suggested by the American Medical Association's CPT guidelines stipulating that each progress note reflect the patient history, a physical examination, and evidence of medical decision making pertinent to the patient's progress and validating why the patient requires ongoing hospital care.

- Progress notes, by the attending practitioner, must be generated at least daily on all acute care patients and more often in acutely and critically ill patients and on those patients where there is difficulty in diagnosis or management of the clinical problems.

- Progress notes must be dated, timed and authenticated.

7.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

7.5-1 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and procedure reports need to provide enough information in the record immediately after surgery in order to manage the patient throughout the postoperative period. This information could be entered as the operative report or as a brief operative note in the EMR.

If the operative report is not placed in the medical record immediately after surgery due to it being transcribed, then a brief op note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This brief op note should contain at a minimum comparable operative report information. These elements include; name of primary surgeon and assistants, procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver. In addition if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.

7.5-2 TISSUE EXAMINATION AND REPORTS

All tissues removed during a procedure, except those specifically excluded by policy of the Medical Staff and consistent with the Joint Commission standards and applicable state and federal regulations, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of

removal, and sent to the Department of Pathology. The pathologist shall document receipt and make such examination is necessary to arrive at a pathological diagnosis. Each specimen shall be accompanied by pertinent clinical information and, to the degree known, the preoperative diagnoses. The examination involves gross and microscopic analyses unless the specimen is classified as limited or exempt. An authenticated report of the pathologist's examination shall be made a part of the medical record.

7.5-3 EXEMPTED CATEGORIES

The Executive Committee of the Medical Staff shall exempt categories of specimens from the requirement to be examined by the Department of Pathology. Such exclusions may include the following:

- Specimens that by their nature or condition do not permit productive examination.
- Therapeutic radioactive sources, the removal of which are guided by radiation safety monitoring regulations.
- Traumatically injured body parts that have been amputated and for which examination for either medical or legal reason is not deemed necessary.
- Specimens that, for legal reasons, are given directly to law enforcement representatives.
- Teeth.

- Placentas that are grossly normal and have been removed in the course of a normal vaginal delivery or c-section delivery, unless medically indicated.
- Tissue from liposuction
- Tissue from abdominoplasty where no gross abnormality is noted by the surgeon.
- Normal-looking skin and scars from cosmetic procedures
- Any implanted hardware including VAD, pacemakers, plates, and screws.
- Dental appliances
- Bone donated to bone bank.
- Tissues (i.e., bone, cartilage) removed only for purposes of gaining surgical access
- Normal fingernails or toenails incidentally removed.
- IUD's

- Foreskin from pediatric circumcision

Whichever, if any, categories are exempted will be reviewed annually by the Performance Improvement Committee, with any recommended revisions being referred to the Executive Committee of the Medical Staff for their consideration.

Specimen exemptions shall be made only when the quality of care is not compromised. The exempt specimens must be properly identified and documented by the physician on the patient medical record as to shape, size, color, quality, etc., at the time of removal.

The following specimens shall be submitted to the pathology department for gross evaluation without mandatory microscopic examination. These include:

-Accessory digits

-Prosthetic cardiac valves without attached tissue

For devices and valves with attached tissue, the tissue will be processed for microscopic examination.

At the request of the attending clinician or at the pathologist's discretion, a pathologist will perform a gross and/or microscopic examination for any specimen including those that may be categorized as exempt or gross only. A pathology report will be produced following the examination.

Any specimens removed that may have legal significance shall be sent to the pathologist.

7.5-4 PRE PROCEDURE REVIEW OF EXTERNAL HISTO-PATHOLOGIC DIAGNOSIS

When a patient enters this hospital to undergo a definitive therapeutic procedure based on histo-pathologic diagnosis made elsewhere, the attending practitioner must present diagnostic slides and reports to this hospital's pathology staff for review and confirmation of the diagnosis. Exceptions may be made in cases in which the attending surgeon will accept responsibility for the outside diagnosis and make a note in the medical record detailing the outside findings.

7.6 ENTRIES AT CONCLUSION OF HOSPITALIZATION

7.6-1 DEFINITIONS

The principal diagnosis, any secondary diagnoses, comorbidities, complications, principal procedure and any additional procedures must be recorded in full upon the patient's

discharge. The attending physician shall cooperate with the hospital to accurately define and describe these diagnoses and procedures using standard terminology, including adding additional documentation or late entries needed to accurately describe the conditions diagnosed and the treatment rendered.

The following definitions are applicable to the terms used herein:

• Principal Diagnosis:	The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
• Secondary Diagnosis: (If applicable)	The diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies or impacts the primary diagnosis.
• Co-morbidities: (If applicable)	A condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day (for about 75% of the patients).
• Complications : (If applicable)	An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.
• Principal Procedure: (If applicable)	The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
• Additional Procedures: (If applicable)	Any other procedures, other than principal procedure, pertinent to the individual stay.

7.6-2 DISCHARGE SUMMARY

IN GENERAL:

A discharge summary must be generated for all patients within 7 days. The summary must: recapitulate concisely the reason for hospitalization; the significant findings, including laboratory findings; any complications; the procedures performed; the

treatment rendered; the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission; post-discharge or outpatient follow-up treatment planned; and any specific instructions given to the patient and/or family, including dietary and activity limitations, as pertinent.

EXCEPTIONS:

A final progress note may be substituted for patients in observation, in same-day surgery, or for hospitalizations less than 48 hours.

7.6-3 INSTRUCTIONS TO PATIENT

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care.

Follow-up care notations should indicate the disposition of the case such as: return to physician's office; transfer to another hospital; transfer to an extended care facility; transfer to a nursing home. If no instructions were required, documentation must be made to that effect.

7.7 AUTHENTICATION

7.7-1 GENERALLY:

All clinical entries in the patient's record must be accurately dated, timed and individually authenticated, and the authors of entries identified through a signature. (Authentication means to establish authorship by written signature, electronic signatures or facsimiles of original written or electronic signatures.)

All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record.

7.7-2 SPECIFICALLY:

The following areas of the medical record require the responsible practitioner's signature:

- Progress notes and orders
- Allied health providers progress notes which require co-signature by the attending.
- History and physical examination
- Immediate preoperative and postoperative progress notes
- All operative or special procedure reports
- Discharge summary
- Narcotic orders and all other clinical entries, diagnoses, orders, reports and

progress notes personally given or written by the attending.

7.8 LATE ENTRIES

Late entries may be made into the record provided that they are labeled as such and reflect the date that the late entry is generated.

7.9 USE OF SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of approved symbols and abbreviations is available at each nursing station.

7.9-1 ABBREVIATIONS

The following is a listing of abbreviations that shall not be used, when ordering medications, when they have been approved by the Medical Executive Committee:

DO NOT USE OFFICIAL LIST	POTENTIAL PROBLEM	USE INSTEAD
U, u (unit)	Mistake for "0" (zero), the number "4" (four) or "cc"	**Write "unit"**
IU (International Unit)	Misread as IV (intravenous) or the number 10 (ten)..	**Write "International Unit"**
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "o" mistaken for "I"	**Write "daily"** **Write "every other day"**
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	**Write X mg** **Write 0.X mg**
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	**Write "morphine sulfate"** **Write "magnesium sulfate"**

Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

- The final diagnosis shall not include the use of symbols or abbreviations.

7.10 CLOSING THE RECORD

No medical record shall be closed until it is complete and properly authenticated. In the event that a medical record remains incomplete by reason of death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Medical Executive Committee and the CMO shall consider the circumstances and may enter such reasons in the record and order it filed. Such generic circumstances shall be described in a policy re: administrative closure, which shall be approved by the Medical Executive Committee and the

CMO.

7.11 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including X-ray films, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the Chief Executive Officer or his designee, or with the approval of the Director of Health Information Management for the purpose of microfilming/storage purposes. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof from the hospital is grounds for such disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the CMO and the Chief Executive Officer or his designee, pursuant to the Medical Staff Bylaws.

7.12 ACCESS TO RECORDS

7.12-1 GENERAL CONDITIONS

- All medical records shall be filed in a physically secure area under the immediate control of the Director of Health Information Management. With respect to electronic medical records, reasonable and appropriate safeguards shall be implemented in connection with the development of technological systems and procedures to guard against unauthorized access, disclosure, corruption, and modification of electronic medical records, which safeguards may include virus checking, firewalls, passwords, encryption and/or other appropriate technical security mechanisms, and shall at all times comply with HIPAA and HITECH (as defined below).

- Access to the areas containing hard-copy medical records shall be limited to the Health Information Management Department personnel with the exception of the Nursing Supervisor on duty, designated staff from other hospital departments and physicians who are completing records, reviewing a record the physician has generated, or reviewing records for the peer review process or other review processes as required.

- All requests for information from, or copies of, a medical record shall be directed to the Health Information Management Department.

- The original medical record, or microfilm, may not be removed from the hospital premises except under proper judicial order or subpoena. With respect to electronic medical records, no transmission of such electronic medical records shall occur except as permitted herein and under applicable law.

- All information contained in the medical record is confidential and the release of information shall be closely controlled

- Judgements about release of medical information contained in the patient's record shall be made with the following considerations:

- Protection of the patient's right to privacy in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") and Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as both may be amended and including any implemented rules and regulations.
- Applicable statutes, legal rulings and local customs. (Refer to Handbook on Medical Records in Massachusetts Health Care Facilities.)

A properly completed authorization shall be required to release medical record information in the following circumstances:

- The patient or his representative
- Attorneys requesting confidential medical information
- Employees, relatives, spouse or friends
- Most governmental agencies (Social Security Administration, Veterans Administration, V.A. Hospitals, etc.)
- Private insurance companies
- Another hospital, non-staff physician, or other health care providers in the absence of a medical emergency

An authorization is generally NOT required to release medical record information in the following circumstances:

- Under normal circumstances, the only information that can be released without the patient's authorization is an acknowledgement of the patient's location within the facility and general condition. If the patient specifically denies the right to release this information, it must be considered confidential.

- For continuity of patient care in other institutions, it is customary to honor the requests of hospitals or clinics licensed by the appropriate licensing authorities for such information as is needed to assist the requesting institution and attending physician to treat the patient promptly and satisfactorily. Releases frequently accompany such requests but they are not necessary.

- Review by Blue Cross or Managed Care Insurers to the extent as may be lawfully made in connection with a claim or other proceedings

- Review by Medicare to the extent as may be lawfully made in connection with a claim or other proceedings under Title XVIII, Social Security Act.

- Review by Medicaid and Maternal and Child Welfare

- Review by the Physician Peer Review Organization to the extent that may be lawfully made in connection with any Medicare, Medicaid, and Maternal and Child Health Program.

- Cases accepted for review by the Massachusetts Industrial Accident Board (Workmen's Compensation Cases.) See Massachusetts General Laws, Chapter 152, Sections 20 &20a.)

- Inspection by any authorized representatives of the Department of Public Health, Division of Hospitals. (See Licensure Rules and Regulations, chapter 2, 11, B, 4, Massachusetts Department of Public Health.)

- Requests from governmental agencies which have appropriate subpoena power, such as the Internal Revenue Service. A summons should, however, be presented by such an agent, a copy of which is to be placed in the medical record of the appropriate patient. These requests are in a category different from requests by local boards of welfare and similar agencies. Refer doubtful cases to the Medical Record Administrator.

- Requests from a physician who did not attend the patient during the period about which an inquiry is made, but who is a medical staff member of Lowell General Hospital and represents that he or she is currently or previously involved in the patient's care.

- Within the hospital: "All previous records shall be made available for use of the physician attending a patient who is readmitted." (See Licensure Rules and Regulations, Chapter 2, 11, B, 6.)

- All appropriate records are made available without patient consent to the various organized staff committees entrusted with reviewing the quality of care within the Hospital.

- Social Agencies: Non-confidential information and pertinent social data (not detailed medical information) may be made available to organized public and private social agencies when the release of such social data may assist the agency in rendering a needed service to the hospital or patient who is also a client of the agency. Such requests for information should be routed to and handled by the appropriate Social Worker/Case Manager. Any questions as to the propriety of the request should be referred to the Medical Record Administrator.

- Upon receipt of a properly issued order or subpoena
- Hospital accreditation and licensure surveys: Medical records may be reviewed to the extent required or expressly authorized by the surveyors to insure compliance with approved standards or statutory regulations provided that the reports of such surveys do not directly or indirectly identify individual patients.
- Filing of lines
- Hospital Affairs: Access to patient records without patient authorization is provided only on a need to know basis for performing internal administrative tasks and conducting quality assurance studies.

A properly executed authorization to release confidential information shall be determined pursuant to the hospital's policy "The Need to Maintain Strict Confidentiality of Patient Information" and "Authorization to Use or Disclose Protected Health Information".

In the case of a minor, the parent or legal guardian must sign except for:

- ◆ Minors who are married, widowed, or divorced
- ◆ Minors who are parents, in which case they may also consent to release information for their children
- ◆ Minors who are members of the Armed Forces
- ◆ A minor who is pregnant or who believes herself to be pregnant
- ◆ Minors who reasonably believe that they are suffering from or have come in contact with diseases defined as dangerous to the public health by statute. (Massachusetts General Laws, Chapter III, Section 6.)

- In the case of mental incompetence or death, the legally appointed guardian, the next of kin, or the executor or administrator of the estate must sign pursuant to the hospitals policy "Disclosure of Protected Health Information to Persons Involved in a Patient's Care" and "Authorization to Use or Disclose Protected Health Information".
- Specific procedures regarding release of patient information shall be in conformance and pursuant to the hospitals policy "The Need to Maintain Strict Confidentiality of Patient Information" and "Authorization to Use or Disclose Protected Health Information".

7.12-2 BY PATIENT OR THEIR LEGALLY DELEGATED REPRESENTATIVES

- The patient, or his legal designee, has the right to access the information

contained in his/her medical record subject to legal constraints such as those governing minors and those patients adjudicated as incompetent. (See Massachusetts General Laws, Chapter 111, Section 70.)

- Patients or their legally delegated representatives may review or obtain copies of their medical records upon proper request to the Director of Health Information Management. The attending physician shall be notified of such requests, where practical, and given a reasonable opportunity to review the record with the patient to explain its contents.

- The Director of Health Information Management shall formulate, with the Medical Records Committee, procedures for all types of releases for consideration of the Executive Committee of the Medical Staff. This policy shall include, pursuant to applicable Commonwealth of Massachusetts law the conditions, if any, under which a provider and/or the hospital can deny access. If access is denied, the patient or other qualified persons will be afforded the right of appeal pursuant to applicable Commonwealth of Massachusetts law.

7.12-3 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall also be made available to authorized personnel, medical staff members or others with an official, hospital-approved interest for the following purposes:

- Automated data processing of designated information

- Activities concerned with assessing the quality, appropriateness and efficiency of patient care.

- Clinical unit/support service review of work performance.

- Official surveys for hospital compliance with accreditation, regulatory and licensing standards.

- Approved educational programs and research studies.

se of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification. Confidential personal information extraneous to the purposes or which the data is sought shall not be used.

7.12-4 FOR RESEARCH PROJECTS

Access to all medical records of all patients shall be afforded to staff physicians, dentists, and podiatrists in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient in the pursuit of determining the eligibility for a patient to be included in a study. Express

patient authorization must be received from the patient prior to the information being included in a study or removed from the premises of Lowell General Hospital or a waiver of authorization that has been granted by Clinical Research Review Committee. Subject to the discretion of the Chief Executive Officer or his designee, former members of the Medical Staff shall also be allowed access to medical records for bona fide study and research in accordance with all applicable state, federal, and HIPAA Privacy Regulations. All such projects shall be reviewed by the Clinical Research Review Committee and approved by the Medical Executive Committee before records can be studied.

7.12-5 BY FORMER MEDICAL STAFF MEMBERS

Subject to the discretion of the Chief Executive Officer or his designee, former members of the medical staff shall be permitted free access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.

7.12-6 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES

Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or the Medical Staff bylaws to receive this information.

Alcohol or drug abuse records must have a special authorization rather than the usual insurance release. This takes precedence over all other situations.

Information regarding HIV/AIDS testing and/or the results of such testing, positive or negative, may not be released without the explicit written consent of the patient, such consent shall conform with the requirements of Massachusetts General Laws, Chapter 111, Section 70F and applicable regulations.

7.12-7 USE OF MEDICAL RECORD ON READMISSION

- In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner.

- Recognizing the need for continuity of patient care, a patient's previous medical records shall be available and provided upon request to the appropriate nursing unit or clinic promptly when a patient is either readmitted or receiving treatment in the Emergency Room or Clinic.

- In the event a patient's past admissions are on microfilm, when requested, pertinent or specified sections of the prior medical record shall be duplicated in hard copy and provided to the appropriate nursing unit, Emergency Room, or Clinic in a timely manner.

  In the event that a patient's prior medical record is not available due to the

microfilming process, the microfilm department/vender shall be notified that a record is needed for patient care and the medical record shall be returned to the Health Information Management Department whereupon they shall forward the medical record to the appropriate requestor promptly.

PART EIGHT: SPECIAL SERVICES UNITS AND PROGRAMS

NOTE: See appendices for policies for Special Services Units and Programs.

8.1 DESIGNATION

Special services units and programs include, but are not limited to, the following:

- Intensive Care Unit
- Emergency Services
- Operating Rooms
- Post Anesthesia Care Units
- Intermediate Care Unit
- Labor and Delivery Unit
- Labor and Delivery PACU
- Newborn Nursery
- Special Care Nursery
- Endoscopy Center
- Pain Center
- Ambulatory Care Unit
- Cancer Center Services
- Medical/Surgery Units

8.2 POLICIES

Appropriate officers, committees, and representatives of the medical staff will develop in coordination with applicable hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, consultation requirements, admission/discharge/transfer protocols, direction/organization of the unit/program, authority of

the physician director of the unit/program, special record-keeping requirements, scheduling of patients, etc. The policies of the various units and programs will be coordinated by, and are subject to the approval of the Executive Committee of the Medical Staff and the Chief Executive Officer or his designee. (See Appendices of these Rules for applicable policies.

8.3 ANCILLARY SERVICE ISSUES

8.3-1 Laboratory services shall be provided in the hospital to insure as complete a service as possible. Examinations, which cannot be made in the hospital, shall be referred to an outside lab which is accredited by CAP or the Joint Commission and has been approved for use by the medical staff.

8.3.2 Radiology services will be ordered in the appropriate sequence of studies as listed in the Radiology guide. Examinations which cannot be made in the hospital shall be referred to an outside vender which is accredited by the Joint Commission and has been approved for use by the medical staff.

PART NINE: HOSPITAL DEATHS AND AUTOPSIES

9.1 HOSPITAL DEATHS

9.1-1 PRONOUNCEMENT

In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable period of time, not to exceed eight hours. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Hospital Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

9.1-2 DETERMINATION OF BRAIN DEATH

Death by brain death criteria is a legal determination based on clinical diagnosis. In all cases, a physician makes the declaration of brain death by clinical and laboratory criteria according to Policy Number HP-RI-05, Determination of Brain Death Guidelines. If there is any controversy over the determination it will be referred to the CMO for further action.

9.1-3 REPORTABLE DEATHS

Reporting of death to the Medical Examiner's Office shall be carried out when required by and in conformance with Commonwealth of Massachusetts Law. The Medical Examiner may accept jurisdiction of the case or he may decline jurisdiction and request that the attending physician certify death. If there is any question of reporting a case to the Medical Examiner, the attending should discuss the issue directly with the Medical Examiner. Policy, Department of Public Health Reporting, attached as Appendix B Currently the law requires the reporting of the following:

a. death where criminal violence appears to have taken place, regardless of the time interval between the incident and death, and regardless of whether such violence appears to have been the immediate cause of death, or a contributory factor thereto;

b. death by accident or unintentional injury, regardless of time interval between the incident and death, and regardless of whether such injury appears to have been the immediate cause of death, or a contributory factor thereto;

c. suicide, regardless of the time interval between the incident and death;

d. death under suspicious or unusual circumstances;

e. death following an unlawful abortion;

f. death related to occupational illness or injury;

g. death in custody, in any jail or correction facility, or in any mental health or mental retardation institution;

h. death where suspicion of abuse of a child, family or household member, elder person or disabled person exists;

i. death due to poison or acute or chronic use of drugs or alcohol;

j. skeletal remains;

k. death associated with diagnostic or therapeutic procedures;

l. sudden death when the decedent was in apparent good health

m. death in any public or private conveyance;

n. fetal death, as defined by section two hundred and two of chapter one hundred and eleven, where the period of gestation has been twenty weeks or more, or where fetal weight is three hundred and fifty grams or more;

o. death of children under the age of 18 years from any cause;

p. any person found dead;

q. death in any emergency treatment facility, medical walk-in center, day care center, or under foster care;

r. fetal death occurring without medical attendance.

s. when the fetal death may have occurred from violence or unnatural causes as determined by the attending physician; or

t. deaths occurring under such other circumstances as the chief medical examiner shall prescribe in regulations promulgated pursuant to the provisions of chapter 30A.

9.1-4 DEATH CERTIFICATE

The death certificate must be signed by the attending physician or his/her designee. If the death occurs in the Emergency Room the ED physician may fill out the death certificate.

A Report of Fetal Death certificate must be completed by the physician when the gestational age of the fetus was at least 20 weeks OR (b) the fetus weighed at least 350 grams.

A standard certificate of death is completed by the physician in the case of neonatal deaths.

9.1-5 RELEASE OF BODY

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff. In a Medical Examiner's case, the body may not be released to other than the Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. Any remains refused to be claimed by next-of-kin will be released to the Public Administrator for completion of funeral arrangements. All other policies with respect to the release of dead bodies shall conform to local and Commonwealth of Massachusetts law.

9.2 AUTOPSIES

Every member of the Medical Staff is expected to be actively interested in securing autopsies when appropriate.

The following circumstances should be considered in determining whether to authorize an autopsy:

- Any death where the known diagnosis would not be expected to result in death. This includes inpatient and outpatient departments and in the Emergency Department, if death is within 48 hours of discharge from the Emergency Department or hospital.
- Unexpected deaths within 48 hours of a surgical or invasive procedure performed in any hospital location, OR, clinic, X-ray, etc.
- Deaths associated with an adverse event including drug or transfusion related reactions.
- Any death within 48 hours of discharge from hospital or Emergency Department whether or not unexpected.

Lowell General Hospital will not permit the transfer of a decedent for purposes of completing an autopsy without the consent of the authorized person defined in "Classes of Persons Authorized to Consent" listed below.

During the autopsy, organs will not be removed from the body for any purpose other than to determine that a medical disease or condition caused the death, or the cause or manner of death, unless the person authorizing the autopsy consents to such use, or unless otherwise required by law.

Autopsies that are authorized by an LGH on-staff physician are performed by an external institution as contracted through the LGH Pathology department.

If an autopsy is not authorized by an LGH on-staff physician caring for the patient at the time of demise, the decedent's next-of-kin will be advised that they may seek the option of securing a private autopsy through their own means.

CONSENT TO AUTOPSY

1.)Proper consent for an autopsy shall be in accordance with the Commonwealth of Massachusetts Law.

The following order of priority is set forth for persons authorized to give consent for an autopsy.

a) An agent of the decedent including, but not limited to, a healthcare agent appointed under a healthcare proxy pursuant to Massachusetts General Law, Chapter 201D, unless the power of attorney for healthcare or other record prohibits the agent from consenting to an autopsy.
(b) The spouse of the decedent
(c) An adult child of the decedent
(d) Either parent of the decedent
(e) An adult sibling (brother or sister) of the decedent
(f) An adult grandchild of the decedent
(g) A grandparent of the decedent
(h) An adult who exhibited special care and concern for the decedent
(i) A person who was acting as a guardian of the decent at the time of death; or
(j) Any other person having the authority to dispose of the decedent's body.

2.) If a member of the highest priority class available to give consent opposes the autopsy and makes such opposition known to the hospital prior to the transport of the deceased, the hospital shall not submit the body for an autopsy.

3.) If the class that is authorized to give consent to an autopsy contains more than one member, the hospital is required to obtain consent from only one member of that class. If a member of the same class as the person who is authorized to give consent to an autopsy opposes the autopsy and makes such opposition known to the hospital prior to the transport of the deceased, the hospital shall not submit the body for an autopsy.

4.) A separated spouse, if available after diligent search, shall explicitly waive consent in writing or by a witnessed telephonic communication before a member of a lower priority class is authorized to give consent.

5.) A person of the highest priority class available to give consent who has not yet attained the age of 18, is not emancipated, or has been adjudicated mentally incompetent may not be the consenting party of record.

6.) A woman who is under the age of 18 years old may consent to the autopsy of her deceased child or fetus.

9.2-1 UNCLAIMED REMAINS

When there is no record of next-of-kin, the, Nursing Administration Coordinator in collaboration with Medical Records Department and with Social Work, will make an exhaustive search of all medical and administrative records in an effort to locate relatives of the deceased to assist with disposition. If none can be found, the Administration Coordinator may request consent for an autopsy from the Chief Medical Officer and the Chief Operating Officer if deemed clinically appropriate.

PART TEN: MEDICAL/DENTAL /PODIATRY STAFF HOME PHONE NUMBERS AND TELEPHONE COVERAGE

10.1 MEDICAL/DENTAL/PODIATRY STAFF HOME PHONE NUMBERS

All physicians, podiatrists, and dentists must make their regular home phone number, cell phone number and business emails available to Medical Staff Services. The numbers are given to the Nursing Supervisor where they are confidentially stored. The Nursing Supervisor uses the numbers only in case of emergency.

10.2 TELEPHONE COVERAGE

Every Staff member is obligated to furnish the Hospital with a telephone number where he or his covering physician can be reached 24 hours a day. Failure to comply with this request will result in the loss of patient admission privileges.

PART ELEVEN: MEDICAL STAFF RECORDS

11.1 MEDICAL STAFF RECORDS

11.1-1 Scope

This Part applies to all records maintained by or on behalf of the Lowell General Hospital Medical Staff, including the records and minutes of all medical staff committees and the credentials files for individual practitioners.

11.1-2 General Policy

The medical staff recognizes that it is important to maintain the confidentiality of medical staff records for both legal and policy reasons. Accordingly, disclosure for medical staff records shall only be permitted under the conditions set forth in this Section of these Rules. The Medical Staff Credentialing files shall be maintained in the Medical Staff Services Office. They shall be kept in locked files.

11.1-3 Access by Persons within the Hospital or Medical Staff

1. Access by Persons Performing Official Hospital or Medical Staff Functions
   - Medical Staff Officers
   - Department Chiefs
   - Medical Staff Committee Members
   - Legal Council
   - Chief Executive Officer or Designated Representative
   - Quality Assurance/Risk Management
2. General Access by Practitioners to Medical Staff Records
   - Credentials
   - Medical Staff Committee Minutes (Peer Review Only)

11.1-4 Access by Persons or Organizations Outside of This Hospital or Medical Staff

1. Credentialing at Other Hospitals

2. Subpoenas

11.1-5 Responsibilities of Members of the Medical Staff

Recognizing the importance of preserving the confidentiality of this information, all the members of the medical staff agree to respect the confidentiality of all information obtained in connection with their responsibilities as staff members. This requirement of confidentiality extends not only to the information contained in the files of the medical staff members and committees, but also to the confidential discussions and deliberations which take place within the confines of medical staff committees.

PART TWELVE: DISRUPTIVE BEHAVIOR – INDEPENDENT PRACTITIONERS/MEMBERS OF MEDICAL STAFF

12.1 DISRUPTIVE BEHAVIOR

The Disruptive Behavior policy is contained in the Lowell General Hospital, the Administrative Policy Manual; Medical Staff Policy and Procedure Manual, and is attached, as Appendix C

PART THIRTEEN: ORGAN AND TISSUE DONATION

13.1 ORGAN AND TISSUE DONATION

The Policy is contained in the Lowell General Hospital Policy and Procedure Manual; Organ and Tissue Donation Policy and is attached as Appendix D

PART FOURTEEN: INTERNAL/EXTERNAL DISASTER EMERGENCY (CODE TRIAGE) ASSIGNMENTS

14.1 INTERNAL/EXTERNAL DISASTER EMERGENCY (CODE TRIAGE) ASSIGNMENTS

In the event a Code Triage is communicated, all on-site physicians and dentists shall report and sign-in to the Medical Staff office during business hours, or Nursing Administration during off-shifts. The Wallace Board Room is the location of the Incident Command Station. Physicians may be assigned to appropriate posts either in the hospital or in alternative care sites and are responsible to report to their assigned station wearing a visible LGH identification badge. No physician or dentist will perform any duties other than those assigned. The Incident Commander, along with members of the Hospital Incident Command System, will work as a team to coordinate activities, and may authorize evacuation from the hospital premises when an emergency exists. In the event of the need for rapid discharge of inpatients from the hospital, all physicians on the Medical Staff specifically agree to relinquish direction of the professional care of their patients involved in the disaster to the physician assigned by the Incident Commander to the disaster discharge.

PART FIFTEEN: PHYSICIAN PERFORMANCE FILES

15.1 PHYSICIAN PERFORMANCE FILES

These files contain monitoring and evaluation of Performance Improvement activities of all the members of the Medical/Dental Staff and are maintained in the Performance Improvement Department.

PART SIXTEEN: AMENDMENT

16.1 GENERAL

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, pursuant to Article XXII of the Medical Staff Bylaws which provides for Medical Executive Committee authority to act for the Staff in adopting or amending Medical Staff Rules, subject to the approval of the Board. The Rules and Regulations may be amended only by both the Medical Staff and the Governing Body; neither may make amendments unilaterally. If significant changes are made in the medical staff bylaws, rules and regulations, or policies, Medical Staff members and other individuals who have delineated privileges are provided with revised texts of the written materials.

PART SEVENTEEN: ADOPTION

17.1 MEDICAL STAFF

These General Rules and Regulations were adopted by the Executive Committee of the Medical Staff on _____, 200____.

_____
Chairman of the Executive Committee of the Medical Staff
Lowell General Hospital

17.2 BOARD OF TRUSTEES

These General Rules and Regulations were approved and adopted by the Board of Trustees on _____ , 200_____, after considering the recommendations of the Executive Committee of the Medical Staff.

_____
President of the Board of Trustees
Lowell General Hospital