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A. GENERAL AND MEDICINE

1. Admission Without Discrimination

Patients may not be denied appropriate hospital care based on the patient's sex, race, color, religion, national origin, ancestry, creed, sexual orientation, marital status, age, newborn status, disability, handicap, or source of payment or any other unlawful basis.

2. Admissions by Staff Only

A patient may be admitted to the Hospital only by a member of the Medical Staff with admitting privileges. Every patient in the Hospital shall be under the care of a physician. A qualified member of the Medical Staff shall be on duty or on call at all times.

3. Exception for Oral Surgeons

With clinical privileges, oral surgeons may perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without other medical problems.

4. Responsible Physician

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 the medical record, for necessary special instructions, and for reports of the patient's condition to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer responsibility shall be entered on the order sheet of the medical record.

5. Protection of Other Patients

The admitting practitioner shall be responsible for providing appropriate Hospital staff such information within their knowledge as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his or her patient might be a source of danger.

6. Provisional Diagnosis

Except in an emergency, all patients that are admitted to the Hospital will have a provisional diagnosis stated on the record at the time of admission.

7. Laboratory Services

Laboratory services shall be provided in the Hospital to ensure quality care. Tests which cannot be done in the Hospital shall be referred to an outside approved laboratory.

8. Standing Orders

Standing orders shall be formulated by the Medical Staff of the Hospital. They will be reviewed or revised as necessary, but at least annually by the Medical Staff.

9. Written and Verbal Orders

All orders for treatment shall be in writing and signed by the ordering practitioner. A practitioner's verbal order shall be considered to be in writing if dictated to a registered nurse. Medical Staff members may dictate verbal orders to a pharmacist, laboratory technician, physical therapist, respiratory therapist, registered dietician, or x-ray technician for functions within each discipline's scope of practice. Verbal orders for any lab test may be taken by a lab technician. The laboratory manager may designate a laboratory unit clerk to take verbal orders for laboratory tests as the lab manager deems appropriate. Verbal orders for all studies may be taken by a radiology technician. The radiology manager may designate a radiology unit clerk to take verbal orders for the radiology exam as the radiology manager deems appropriate. Unit clerks and Licensed Practical Nurses (LPNs) may take limited verbal orders from a physician member of the medical staff (not a medical student or a nurse under the direction of a medical staff member). "Limited verbal orders" are defined as and limited to:

- All diet orders
- All activity orders
- Radiology orders not involving a prep or contrast
- Laboratory orders not involving a pre-medication or timed drug levels.

Uniformly excluded are:

- All medication orders
- All intravenous placement and intravenous fluid orders

All verbal orders and telephone orders, regardless of where received, must be read back to the ordering practitioner and written in the patient medical record with the name of the ordering practitioner and signed by the person to whom the order was dictated. The ordering practitioner must sign all verbal orders within 48 hours (with exception of standing orders). The primary responsible physician may, at his or her discretion, countersign all verbal orders of other physicians.

10. Inpatient Emergency Care

All Active and Provisional members of the Medical Staff shall make arrangements to provide 24-hour care to their patients. When the patient's attending physician cannot be reached, the Shawano Medical Center Physician Coverage Responsibility for Inpatient Care Policy will be followed.

11. Discharge/Release

Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident must be made in the patient's medical record. An attempt must also be made by nursing personnel to have the patient sign the designated release form.

12. Autopsies

It shall be the duty of all Medical Staff members to secure consent for autopsies if indicated. An autopsy may be performed only with a written consent signed in accordance with State law.

13. Automatic Stop Orders

All medications subject to automatic stop orders are discontinued after the specified time interval unless:

a. They are reordered by the physician; or
b. The physician's order specifies an exact number of doses or time interval for administering the medication.

The physician is notified prior to discontinuing any medication. When a patient goes to surgery, all medication orders are automatically canceled.

Medication subject to automatic stop orders and their time limitations are identified in medication orders policies and procedures.

14. Investigational Drugs

a. Except as provided in subsection b, if investigational drugs are to be used within the Hospital, permission from the Medical and Pharmacy Committee and the Ethics Committee must first be received, and if approval is given, administration of the drugs must be under the control and supervision of the attending physician (use of the investigational drug requires patient consent).
b. A hospitalized patient who is currently involved in an investigational drug study through an outside agency (private practitioner or clinic) may continue use of the investigational drug if such use is approved by the patient's attending physician. Investigational drugs are not dispensed by the Hospital and shall only be dispensed pursuant to the applicable protocol in place for the study.

15. X-Ray Orders

Requests for x-ray examinations will contain a statement as to the reason for the examination on the x-ray request form.

16. Ethics

As a condition of staff privileges, each practitioner agrees that he or she will not:

a. rebate a portion of his or her fee;
b. deceive a patient as to the identity of the operating surgeon or any other practitioner; and
c. delegate responsibility for the care of a hospitalized patient to another individual not qualified to undertake the responsibility.

17. Consent for Treatment

A general consent form signed by, or on behalf of, every patient admitted to the Hospital must be obtained at the time of admission.

18. Legible Orders

All orders must be written clearly, legibly, and completely. Orders which are illegibly or improperly written will not be carried out until rewritten or understood by qualified hospital staff.

19. Consultations

All qualified practitioners with clinical privileges in this Hospital can be called for consultation within his or her area of expertise. Requests for consultations are to involve verbal or written ~~direct~~ communication from the requesting practitioner to the consulting practitioner.

20. Care Questioned by Nurse

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor, who in turn may refer the matter to the Administrator on-call. If warranted, the nurse may bring the matter to the attention of the chairperson of the clinical area involved or the President of the Medical Staff.

21. Physician Assistants

Physician Assistants may perform physicals and document history. Orders may be written with counter-signature of supervising physician within 24 hours of the history and physical being completed by the Physician Assistant (see Allied Health Order Grid). Physician Assistants need to be sponsored by one or more supervising physicians and appointed to the Allied Health Professional Staff as Dependent Allied Health Professionals. Physician Assistants working in the ER or Urgent Care and appointed to the Allied Health Professional Staff will be allowed to practice under the general supervision of a physician to the full extent of their license and training.

22. Advanced Practice Nurse Prescribers Advanced Practice Nurse Prescribers (APNPs) may perform physicals and document history. Orders may be written without physician countersignature if the order is within the scope of practice of an APNP to issue independently, and all other orders shall be counter-signed by a supervising physician within 24 hours of the order being written by the APNP. (see Allied Health Order Grid). APNPs need to have a collaborative agreement with one or more physicians and be appointed to the Allied Health Professional Staff as Dependent Allied Health Professionals. APNPs working in the ER or Urgent Care and appointed to the Allied Health Professional Staff will be allowed to practice in collaboration with the physicians to the full extent of their license and training.

23. Licensed Registered Nurse Midwifes
Licensed Registered Nurse Midwifes may perform physicals and document history. Orders may be written without physician countersignature if the order is within the scope of practice of a Licensed Registered Nurse Midwife to issue independently, and all other orders shall be countersigned by a supervising physician (see Allied Health Order Grid). Licensed Registered Nurse Midwifes need to be sponsored by a physician with postgraduate training in obstetrics with whom they have a written collaboration agreement, and appointed to the Allied Health Professional Staff as Dependent Allied Health Professionals. Licensed Registered Nurse Midwifes appointed to the Allied Health Professional Staff will be allowed to practice in collaboration with their sponsoring physician to the full extent of their license and training.

24. Nurse Practitioners
Nurse practitioners who are not APNPs will be under the direction of a supervising physician. Nurse practitioners will be allowed to order outpatient radiology studies, laboratory studies, evaluations and/or treatment for physical therapy and speech therapy as delegated medical acts, with countersignature by the supervising physician (see Allied Health Order Grid). Nurse practitioners will also be allowed to do pre-admission history and physical exams, with countersignature by the supervising physician, and have access to patient medical records. Reports from these studies will be sent back to the attending physician and ordering practitioner.

25. Allied Health Order Grid
Physician Assistants, APNPs, Nurse Midwifes, and Nurse Practitioners are authorized to order laboratory tests, physical therapy, and radiology studies within the parameters identified in Rules 22-25 above.

ORDERING AND COUNTERSIGNATURE REQUIREMENTS FOR ALLIED HEALTH PROVIDERS[1]

Test	APNP[2]	Advanced Practice Nurse[3]	Nurse Midwife[4]	PA
Lab				
May midlevel provider order the tests?	APNP may order lab tests to promote case management. Physician collaboration[5] is required, but no physician countersignature is necessary. N 8.10(6) HFS 124.17 requires that the order must come from a physician or other individual authorized by the medical staff to order tests.	APNs who are not APNPs may write orders as a delegated medical act. A physician must first have issued protocols or written or verbal orders regarding the order. An APN may only accept those delegated medical acts he or she is competent to perform based on his or her nursing education, training and experience. To write an order, the APN must be under the general supervision of the physician. Countersignature of the patient's medical record is required to document appropriate supervision of the APN and demonstrate physician responsibility for the patient's care.	Same as for APN.	Yes, per Med 8.07(2)(b), but PA's entire practice must be under physician supervision. Countersignature of the patient's medical record is required to document appropriate supervision of the PA and demonstrate physician responsibility for the patient's care. HFS 124.17 requirement also applies.

[1] This chart generally discusses a midlevel provider's scope of practice under state law for ordering diagnostic tests.
[2] In Wisconsin, an advanced practice nurse prescriber ("APNP") is an advanced practice nurse who has been granted a certificate by the State of Wisconsin to issue prescription orders. N 8.02(2).
[3] In Wisconsin, an advanced practice nurse ("APN") is a licensed RN who is certified by a national certifying body approved by the Board of Nursing as a Nurse Practitioner ("NP"), Clinical Nurse Specialist ("CNS"), Certified Registered Nurse Anesthetist ("CRNA") or Certified Nurse-Midwife ("CNM"). N 8.02(1).
[4] In Wisconsin, a nurse-midwife is an advanced practice nurse who has been granted a license to engage in the practice of nurse-midwifery in Wisconsin. N 4.02(5m).
[5] Collaboration is defined as a process which involves two or more health care professionals (at least one physician) working together, in each other's presence when necessary, each contributing one's respective area of expertise to provide more comprehensive care than one alone can offer. N 8.02(5).

Test	APNP[2]	Advanced Practice Nurse[3]	Nurse Midwife[4]	PA
		HFS 124.17 requirement also applies.		
Physical Therapy				
May midlevel provider order physical therapy?	Yes, but only if allied health staff are allowed to order physical therapy under the medical staff bylaws. HFS 124.21 (4). Under the 2005 Wisconsin Act 187 and § 448.56 Wis. Stats., a person may practice physical therapy only upon the written referral of a physician, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber.	Yes, only as a delegated medical act after a physician, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber has previously diagnosed the condition requiring therapy, and if allied health staff are allowed to order physical therapy under the medical staff bylaws. HFS 124.21 (4).	Same as for APN.	Same as for APN.
Respiratory Therapy				
May midlevel provider order t respiratory therapy?	No. HFS 124.22(4) requires a physician order.	Same as for APNP.	Same as for APN.	Same as for APNP.
X-ray and Electrocardiogram (EKG)				
May midlevel provider order the tests?	APNP may order x-rays and EKGs to promote case management. Physician collaboration is required, but no physician countersignature is necessary. N 8.10(6) HFS 124.18 requires that the order must come from a physician or other individual authorized by the medical staff to order x-rays.	APNs who are not APNPs may write orders as a delegated medical act, as described under the lab section. Countersignature of the patient's medical record is required to document appropriate supervision of the APN and demonstrate physician responsibility for the patient's care. HFS 124.18 requirement also applies.	Same as for APN.	Yes, per Med 8.07(2)(b), but PA's entire practice must be under physician supervision. Countersignature of the patient's medical record is required to document appropriate supervision of the PA and demonstrate physician responsibility for the patient's care. HFS 124.18 requirement also applies.

Test	APNP[2]	Advanced Practice Nurse[3]	Nurse Midwife[4]	PA
Drugs				
May midlevel provider order the medication?	Yes, if the nurse has been certified as an APNP and the nurse collaborates with a physician. No counter-signature is required. N 8.06.	If not an APNP, then order may be as a delegated medical act as described in the lab section. Countersignature is required.	Same as for APN.	Yes, if in accordance with written guidelines and under physician supervision. Med 8.07(2)(i) and Med 8.08. Physician countersignature is required on prescription order.
Occupational Therapy				
May midlevel provider order occupational therapy?	Yes. Referrals for OT may be accepted from advanced practice nurses, physician assistants, and other health care professionals. OT 4.03(2) HFS 124.21(4) requires that occupational therapy services be given in accordance with orders of a physician, podiatrist, or any allied health staff member who is authorized by medical staff bylaws to order the service.	Same as for APNP. HFS 124.21(4) requirement also applies.	Same as for APN. HFS 124.21(4) requirement also applies.	Same as for APNP. HFS 124.21(4) requirement also applies.

26. Counselors for Treatment Programs

By order of a physician member of the Medical Staff, counselors employed by alcohol and other drug abuse treatment programs under contract with 51.42 Boards may see patients admitted for detoxification to assess whether they are candidates for treatment. Counselors will document findings and recommendations on the consultation form in the medical record.

27. Medical Students/Nurse Practitioner Student/Physician Assistant Students

Medical students, Nurse Practitioner Students and Physician Assistant Students are not staff members and have no privileges; rather, they are preceptees performing specific tasks under the direction of, and with the specific approval of, their Medical Staff preceptors in accordance with the Medical Student Policy. The specific duties of each student are determined on an individual basis and are adjusted by the preceptor constantly during the student's experience here. The nursing staff confirms preceptees' orders with the preceptor before carrying them out.

28. Infection Control Authority

The Medical, Pharmacy, Special Care and Infection Control Committee~~s~~ has authority to institute any appropriate infection control measures or studies when there is potential danger to patients or personnel.

29. Authority to Isolate Patients

Isolation precautions are directed toward preventing the spread of infection among patients and personnel within the Hospital. The patient's physician should stipulate the diagnosis and order isolation of patients with illnesses requiring it. If the physician does not do so, the Registered Nurse and/or Infection Control Coordinator has the authority to introduce isolation precaution when deemed necessary for infection control.

30. Reference Laboratories

Reference laboratories may be used by the Hospital upon recommendation by Hospital Administration and approval by Medical Staff and Governing Body.

31. Consultation –Medical Surgical & Special Care Unit**s** Medical Staff

a. Medical Staff coverage meets the medical care needs of patient(s) within the Medical Surgical & Special Care Units by:
   (1) The Medical Staff, through its rules and regulations, determines the circumstances under which consultation, in person or per phone, by a qualified specialist is required.
   (2) These circumstances include, but are not limited to:
      - The patient is a potential or definite transfer to another facility for a different level of care.
      - The admitting physician desires a "specialist(s)" input into the patient(s) plan of care.

b. The admitting physician requests consult from fellow physician on the Medical Staff for input on patient(s) plan of care:
   (1) The nursing staff will assist the physician in locating the "specialist" and/or requested Medical Staff member for consultation.

32. Credentialed Persons Health Status

It is required that all persons giving direct patient care who go through the credentialing process (initial and reappointment) have the following tests:

a. Proof of Rubella immunity by titre or injection (date)
b. Yearly TB skin test or, if a positive reactor, sign a Signs & Symptoms Sheet

33. Continuing Medical Education

Shawano Medical Center, in its ongoing effort to offer quality patient care, will actively encourage and promote continuing medical education. The Credentials/Library Committee shall have the responsibility to coordinate educational activities for all medical staff members.

NOTE: SMC will be recommending changes to the existing Medical Staff Lounge that could better suit the educational needs of the practitioners.

34. Residents

All residents, prior to starting at the Hospital, will provide the Hospital with:

1. A copy of their Wisconsin medical license,
2. A copy of their medical diploma,
3. A reference letter from their Residency Director.
4. A completed and signed Scope of Practice Agreement provided by the Hospital. Their assigned preceptor will approve the Scope of Practice prior to the resident's start date.

Progress notes and orders will be co-signed within 24 hours. Resident(s) will be under the direct supervision of Active, Courtesy or Provisional staff.

35. IV Blood/Blood Products and IV Antibiotics Orders

Please refer to Shawano Medical Center Non-Staff Physician Orders policy for guidance in this issue.

B. OBSTETRICS AND GYNECOLOGY

1. Prenatal Histories

Prenatal histories are to be on file in the Obstetrics Department after the first prenatal visit and updated at 20, 32, 34, 36 weeks and weekly thereafter, as applicable. Prenatal histories must note complications, RH status and other matters essential to adequate prenatal care. If possible, all obstetrical patients are to be preadmitted.

2. Sterilization Consent
Sterilization consent forms are to be signed by all patients who are to be sterilized.

3. Prenatal Histories From Office
There shall be a prenatal history and physical examination on every obstetrical patient. The original copy of the prenatal record of the patient kept by the physician in his or her office may be substituted for the history and physical examination done in the Hospital. H&P will be updated on admission.

4. Delegated Physician Responsibility
All staff members having obstetrical privileges must delegate responsibility for their patients' management to another similarly qualified and privileged physician should they be absent from the community or unavailable for any reason. The second physician should be notified by the attending physician prior to his or her being unavailable, and should be informed of any relevant medical information relating to the patients likely to deliver during the absence.

5. Consultations
There shall be consultation prior to the performance of a Primary Caesarean section.

Concurrence of two Obstetrics practitioners shall be obtained prior to the performance of a Primary Caesarean section. This concurrence is subject to the availability of Obstetrics practitioners and required only as long as the mother and baby's health and safety are not endangered.

If the physician attending a patient who is attempting a vaginal birth after Caesarean section does not have Caesarean Section privileges, the attending physician shall consult with a physician with such privileges upon admission or active labor.

C. ABORTIONS

1. First Trimester
An abortion during the first trimester of pregnancy will be allowed.

2. Choice to Participate
No physician or Hospital personnel will be compelled to perform or participate in an abortion procedure if it is against his or her religious, moral or ethical principles.

3. Beyond First Trimester

Abortion beyond the first trimester shall not be allowed unless a life or health threatening condition to the mother exists, and this must be documented by a written consultation from another member of the Medical Staff.

D. SURGERY

1. Preop Records

Except in emergencies, an appropriate history and physical work-up, as well as the preoperative diagnosis and required laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

2. Written Consent

Written, signed surgical consent shall be obtained prior to the operative procedure, except in those conditions when the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. Emergency circumstances involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian, or next of kin shall be fully explained in the patient's medical record. A consultation in such circumstances may be desirable before the emergency operative procedure is undertaken, if time permits.

3. Privileges Required

Surgery shall be performed by practitioners only according to privileges granted to them through the Medical Staff and by the Governing Body.

4. Anesthesia Record

Anesthetists shall maintain a complete anesthesia record to include evidence of anesthetic follow-up of the patient's condition.

5. Anesthesia Risk Classification

The operating surgeon will record the anesthesia risk classification of the patient on the anesthetist's record sheet or the doctor's progress notes. The classifications are as follows:

Class I: No disease other than surgical pathology; no systemic disorders.
Class II: Moderate systemic disturbances due to general disease or surgical condition.
Class III: Severe systemic disturbances due to general disease or surgical condition.
Class IV: Systemic disorder an imminent threat to life.
Class V: A moribund patient.

6. Physician Assistant Is Not Required

For all major and minor surgical procedures, it shall be the responsibility of the operating surgeon to determine whether a physician or qualified assistant **is** required.

7. Tissues Examined

All tissues removed at the time of operation shall be sent to the Hospital pathologist who shall make such examination as he or she may consider necessary to reach a tissue diagnosis, except the following for which a "gross only" exam is allowed:

- Bones (except bone tumors)
- Bunions
- Femoral head from hip replacements
- Hardware, foreign bodies, etc.
- Hernia Sacs
- Lamina (disc is routine)
- Teeth
- Tonsils and adenoids (under age 16)
- Traumatic amputations
- Veins (except from heart surgery)

The above may also be given a microscopic exam if the surgeon or pathologist deems it necessary. The pathologist's authenticated report will be made part of the patient's medical record.

The following list includes prosthesis/artificial devices and specimens that routinely do not need to be sent to pathology:

- Cataracts
- Placentas (from uncomplicated C-section or normal vaginal delivery)
- Medical devices, such as, catheters, gastroscopy tubes, myringotomy tubes, stents, and sutures that have not contributed to patient illness, injury, or death.
- Cardiac Pacemakers
- IUD's
- Norplant
- Orthopedic pins, nails, screws and plates
- Intraocular lens
- Temporary tissue expanders containing saline
- Arthroscopic joint surgery fragments
- Clots from graft endarterectomy
- Newborn foreskin
- Non pathologic tissue removed during the course of surgery such as sinus exploration
- Old incidental incisional scars

The following list includes prosthesis/artificial devices and specimens that routinely do need to be sent to pathology:

- Any surgical instrument or surgical sponge requiring a secondary surgery to remove.
- Bullet and Bullet fragments not given to law enforcement
- Implanted breast prosthesis (And all other type of implanted prosthesis except dental, intraocular lenses, temporary tissue expanders and Norplant)
- Orthopedic joint prosthesis

8. Surgeon Responsible

The staff member with the privileges to perform the operation shall assume complete and full responsibility before and after surgery for any case when he/she performs a major operation for a staff member who has lesser privileges.

9. Ready for Surgery

Surgeons must be in the operating room and ready to begin surgery at the scheduled time. Undue postponements of surgery because of the surgeon's being late may necessitate rescheduling the surgery.

10. Post Op Responsibility

It is the complete responsibility of the operating surgeon to follow the patient postoperatively, write the postoperative orders, and discharge the patient either from the Hospital or to the care of another physician when the surgical problem is resolved.

11. Visitors in OR

Visitors are not permitted in the operating room, except by permission of the attending surgeon and Hospital administration.

12. Signed Consultation

When consultation is required for elective surgery, the consultation shall be completed and signed the evening of the day preceding surgery and shall be made a part of the patient's record prior to the surgery.

13. Preop Exam

Preoperative screening for all patients having general anesthesia will comply with § HFS 124.20 of the Wisconsin Administrative Code, including a pre-anesthetic evaluation by a person qualified to administer anesthesia with recorded findings no more than 48 hours before surgery and a pre-anesthetic visit by the anesthetist.

14. Dental Admission

A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff.

a. Dentist's Responsibility

(1) A detailed dental history and dental physical examination justifying Hospital admission.

(2) A detailed description of the examination of the oral cavity and a preoperative diagnosis.

(3) A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.
(4) Progress notes as are pertinent to the oral condition.
(5) Clinical resume (or summary statement).

b. Physician's Responsibility
(1) Medical history pertinent to the patient's general health.
(2) A physical examination to determine a patient's health status while hospitalized.

c. The discharge of the patient shall be on written order of the physician member of the Medical Staff.

d. All patients given general anesthesia with the procedure being done by a non-physician requires a designated physician to be present in the hospital building. Anesthesia will take the responsibility of making sure there is a physician present in the building.

e. Anesthesia will give sedation as necessary when the procedure is being done by a non-physician, pursuant to a standing order for this, with the physician responsible for the patient's medical care to sign off at a later time.

15. Podiatric Admission

A patient admitted for podiatric care is the responsibility of both the podiatrist and a physician member of the Medical Staff.

a. Podiatrist's Responsibility
(1) A detailed podiatric history and podiatric physical examination justifying Hospital admission.
(2) A detailed description of the examination of the foot and a preoperative diagnosis.
(3) A complete operative report describing the findings and technique. Progress notes as are pertinent to the foot condition.
(4) Clinical resume (or summary statement).

b. Physician's Responsibility
(1) Medical history pertinent to the patient's general health performed within 48 hours of the procedure.
(2) A physical examination to determine a patient's health status while hospitalized.

c. The discharge of the patient shall be on written order of the physician member of the Medical Staff.

d. All patients given general anesthesia with the procedure being done by a non-physician requires a designated physician to be present in the hospital building. Anesthesia will take the responsibility of making sure there is a physician present in the building.

e. Anesthesia will give sedation as necessary when the procedure is being done by a non-physician, pursuant to a standing order for this, with the physician responsible for the patient's medical care to sign off at a later time.

16. Consultations Required
See Obstetrics section regarding consultations for Primary Caesarean.

17. Postanesthesia Recovery Room Discharges
Decisions relative to the discharge of a patient from the recovery room shall be made by a member of the Medical Staff .

18. Surgery Cancels Orders
When a patient undergoes surgery, all standing drug orders will be automatically canceled and rewritten after the surgical procedure.

19. Autopsies
An autopsy may be done at the request of the attending physician and/or next of kin or as indicated per Wisconsin State Law.

E. EMERGENCY ROOM

1. Call Requirements
Every physician member of the Active and Provisional Medical Staff shall be required to provide back-up call for Emergency Room physicians.

2. Call for Senior Physician
Any physician age 60 and over who is a member of the Active or Provisional Staff will not be required to take Emergency Room call, unless he or she specifically requests to take such duty.

3. Instructions to Patients
After care instructions are to be given to each patient seen in the Emergency Room, and this is to be documented and signed by the physician and patient. A copy is given to the patient.

4. Physician Sees All Patients
Any patient to be transferred from the ER to another in-patient hospital facility will be seen by the ER physician prior to transfer. EMTALA regulations will be met regarding all transfers. All Emergency Room patients will be seen by the E.R. physician unless arrangement is made by an attending M.D. to see a specific patient.

5. Consults for Suicide Patients
All suicidal patients need treatment. Treatment may be medical or psychiatric. The ER physician should assess the problem(s) and decide which treatment is needed and convey this information to the physician on-call and the social services agency indicated. Law enforcement also shall be notified if necessary to

prevent or lessen a serious and imminent threat to the health of safety of the patient or the public.

6. Transfers to Other Departments

As the ER should be reserved for trauma and acute illness, under disaster situations patients who can be treated in another area of the hospital should be transferred to that area for treatment or surgery following the disaster plan. Hospital's transfer policy governs transfers.

7. Physicians On-Call

Refer to Shawano Medical Center's Emergency Department Call Coverage Responsibility for Staff Members Policy as to Physicians On-Call responsibilities.

F. MEDICAL RECORDS

1. Practitioner Responsible

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaints, personal history, family and social history, history of present illness, physical examination, all diagnostic and therapeutic orders, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume, autopsy report when performed, and anatomical gift information.

2. History and Physical

A complete admission history and physical examination shall be recorded or dictated within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. When a complete history has been recorded and a physical examination performed by a member of the Medical Staff within a week prior to the patient's admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical records in lieu of the admission history and report of the physical examination, provided an interval note is written within 24 hours of admission, updating any pertinent changes in history or physical findings. In the event of a readmission for the same condition within 30 days, a reference to the previous exam, with interval notes and a note of any pertinent changes in physical findings shall be recorded, and present salient facts will be considered an adequate examination.

3. Filed When Complete

No medical record shall be filed until it is complete, except on order of the Health Information Management/Utilization Review Committee.

4. History and Physical Not Recorded
When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, adequate recording of pertinent systems and provisional diagnosis shall be documented in writing on the progress sheet by the attending practitioner unless the attending practitioner states in writing that such delay would be detrimental to the patient.

5. Progress Notes
Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Progress notes shall be written at least every day.

6. Entries Dated
All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

7. Abbreviations
Symbols and abbreviations may be used only when they have been approved by the Health Information Management/Utilization Review Committee and are on file in the Health Information Management Department. Abbreviations identified and on file in the Health Information Management Department as "dangerous/unapproved abbreviations" shall not be used at any time.

8. Operative Reports
Operative reports shall include a detailed account of the findings at surgery as well as details of the surgical technique, specimens removed, post-operative diagnosis, estimated blood loss as indicated, and the names of the primary performing practitioner and any assistants. Operative reports shall be written or dictated immediately following surgery, for outpatients as well as inpatients, and a report properly signed by the surgeon and made a part of the patient's current medical record. "Immediately" is defined as within six (6) hours.

9. Consultations
Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendation. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the records, be recorded prior to the operation. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

10. Prenatal Records
The current obstetrical records shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission.

11. Final Diagnosis

Final diagnosis shall be recorded in full in each patient record without the use of symbols or abbreviations, and dated and signed by the responsible physician. This will be deemed equally as important as the actual discharge order.

12. Discharge Summary

A discharge clinical resume (summary) shall be written or dictated on all Hospital admissions. It shall include the final diagnosis, reason for hospitalization, significant findings, procedures performed, condition of the patient on discharge and any specific instructions given the patient or family or both. In all instances, the content of the medical records shall be sufficient to justify the diagnosis and warranted treatment and end results. All summaries shall be completed and authenticated by the responsible practitioner within 30 days following discharge.

13. Release of Information

Written informed consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information under Wisconsin and federal law.

14. Removal of Records

Records may be removed from the Hospital's jurisdiction and safe keeping only in accordance with a court order, federal subpoena or specific provision of law authorizing or directing removal. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In cases of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.

15. Routine Orders

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

16. Incomplete Records

If a medical record is not completed within 30 days of discharge the record will be permanently recorded as delinquent. If a practitioner develops a backlog of incomplete records, a Notice of Incomplete Records will be sent to that physician which will also stipulate which records are nearing the 30 day point. If the physician does not respond within seven days the Chairperson of the Health Information Management-Committee or the Chief of Staff will personally address the issue with the responsible physician. If the records remain incomplete after this personal request the Chief Executive Officer or his or her designee may initiate a notice of temporary suspension of privileges. The responsible practitioner will be asked to complete the records within 24 hours of receipt of this notice. If the records remain incomplete after that time the suspension will be implemented and remain in effect until all the records have been completed. An

evaluation of each practitioner's compliance with record completion will be maintained in his or her peer review file for reference as appropriate. If a suspension remains in effect 30 days or more and the patient's care is compromised by the untimely completion of records, the suspension of any physician member of the Medical Staff will be reported to the National Practitioner Databank.

17. Emergency Care Records

A medical record shall be kept on every individual seeking emergency medical care, and shall contain the following, unless the individual voluntarily leaves the Hospital before he or she is assessed in which case such fact should be documented:

a. Patient identification;
b. History of disease or injury;
c. Physical findings;
d. Laboratory and x-ray reports, if any;
e. Diagnosis;
f. Record of Treatment;
g. Disposition of the case;
h. Authentication, history and physical, progress notes and orders, operative reports and discharge summary, and signature of face sheet as required by § HFS 124.14(3)(b); and
i. Appropriate time notations, including time of the patient's arrival, time of physician notification, time of treatments, including administration of medications, and time of patient discharge or transfer from the service.