

ARTICLE II

ADMISSION

2.1 Who May Admit Patients

A patient may be admitted to the Hospital only by Physicians, Dentists and Oral Surgeons who have been appointed to the Medical Staff and who have Clinical Privileges to do so. The admitting physician is the doctor who accepts the patient for admission and manages the patient until the attending physician assumes care of the patient. The attending physician is the doctor who assumes primary responsibility for the patient's medical care and treatment during the inpatient stay.

Podiatrists and Certified Nurse Midwives may co-admit patients to the Hospital with a Physician appointed to the Medical Staff. Psychologists may not admit or co-admit patients to the Hospital. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Hospital has facilities and personnel. When the Hospital does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Hospital, the Hospital or attending Practitioner, or both, shall assist the patient in making arrangements for care in a alternate facility so as not to jeopardize the health and safety of the patient. Except in an emergency, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

2.2 Attending Practitioner Responsibilities

Each patient shall be the responsibility of a designated Appointee to the Medical Staff (or a licensed independent practitioner who has been granted privileges by the Board), who shall be responsible for the management, treatment and care coordination. At the time of admission of a dental or podiatric patient, a patient being treated by a psychologist, or an oral surgery patient with pre-existing medical problems, a Physician appointed to the Medical Staff shall be consulted and responsible for the admission, history, physical examination, care of any medical problem that may be present at the time of admission or during hospitalization and, if a medical problem exists, shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. At or before the time of admission of such patient, it is the responsibility of the dentist, podiatrist, or psychologist to obtain a medical consult in accordance with the Medical Staff Bylaws. The dentist, oral surgeon, podiatrist, or psychologist is solely responsible for the dental, podiatric, or psychological history, examination, diagnosis, operative report and dental, podiatric, or psychological discharge summary.

The attending Practitioner shall be responsible for the coordination and communication of medical care and treatment of the patient among all practitioners involved in the patient's care treatment and services, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the

patient to any referring Appointee of the patient. Whenever these responsibilities are transferred to another Practitioner, a note covering the transfer of responsibility shall be entered on the medical record. The attending Practitioner shall be responsible for providing the Hospital with such information concerning the patient as may be necessary to protect the patient or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

All patients admitted to the Hospital as inpatients and who are not critical care patients, must have a Practitioner visit within twenty-four (24) hours of admission. All patients with observation status placement must have a Practitioner visit within twenty-four (24) hours of observation status. Practitioner visits for critical care patients must occur within twelve (12) hours of the critical care unit admission. H & P requirements are determined by the Medical Staff in administrative polices which must be consistent with CMS and The Joint Commission editions and standards.

2.3 Alternate Coverage for Hospital Patient Situations

Each Medical Staff Appointee shall provide assurance of immediate availability of adequate professional care for his patients in the Hospital by being available or having available an alternate Medical Staff Appointee with whom prior arrangements have been made and who has like Clinical Privileges at the Hospital sufficient to care for the patient. A Medical Staff Appointee who will be out of town shall provide appropriate communication of the alternate coverage arrangements. Failure to meet the above requirements may result in loss of Clinical Privileges. Medical Staff Appointee who will be out of town shall, on the order sheet of the chart of each of his patients, indicate in writing the name of the Medical Staff Appointee who will be assuming responsibility for the care of the patient during his absence.

In any immediate life-threatening situation, the In House Hospitalist service physician should be called.

For any non-immediate emergent situation, should the attending or consulting Practitioner needed become unavailable, the following steps will be taken by the Clinical Coordinator, Nurse Manager, or Administrative Clinical Coordinator (house supervisor) to assure care for all hospital patients:

- (a) The covering Practitioner will be contacted. Failing this:
- (b) The appropriate Unit Medical Director will be contacted if applicable. Failing this:
- (c) The Chair of the Department will be contacted to arrange for care for the patient. Failing this:
- (d) The President of the Medical Staff will be asked to intervene.

- (e) Hospitalist service physicians may be called and asked to see in-house patients that are not within their service only in emergencies and are not to be called for ongoing medical management.

2.4 Admission Office Procedures

- (a) No patient will be admitted until the Hospital's consent to treatment form has been signed by the patient or his legal representative, unless there is implied consent for an Emergency Admission where the patient is unable to sign and a legal representative is not available.
- (b) At the time of admission or as soon as possible thereafter, each patient shall be fitted with the Hospital's means of patient identification.

2.5 Priorities for Admission

In any case in which a patient requires admission, the Practitioner shall first contact the AO's to ascertain whether there is an available bed. No patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated in case of an emergency, such statement shall be recorded as soon after admission as possible. The Patient Registration office will admit patients on the basis of the following order of priorities:

- (a) **Emergency Admissions** - This category includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would increase that harm or danger. In an emergency admission, the attending Practitioner will be required to furnish complete documentation of the need for this admission within twenty-four (24) hours. The attending Practitioner's failure to furnish this documentation, or evidence of willful or continued misutilization of this category of admission, will be brought to the attention of the MEC for appropriate action.
- (b) **Urgent Admissions** - This category includes non-emergency patients whose admission is considered urgent by the attending Practitioner and the Chair of the Quality Improvement Committee (QIC). When urgent admissions and elective preoperative admissions cannot be simultaneously accommodated, an "urgent" waiting list shall be initiated and prioritized by the Chair of the QIC. It shall be the policy to admit urgent admissions within seventy-two (72) hours.
- (c) **Elective Admissions** - This category includes elective admissions for all services.

If there is any question concerning the admission of a patient, the Chair of the Total Case Management Committee, or a physician representative from this Committee, shall determine the necessity for, or deferment of, the admission.

2.6 Emergency Admissions

The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart within twenty-four (24) hours after admission. In the case of emergency admissions, patients who do not already have a personal admitting Practitioner will be assigned to a medical staff appointee with clinical privileges in the department to which the diagnosis indicates an assignment.

2.7 Routine Lab Work Required

- (a) Pre-admission testing for elective surgical patients shall be authorized by the attending Practitioner and/or anesthesiologist. The results of pre-admission testing shall be valid for the length of time specified by the Department of Anesthesia and certified in the patient's record.
- (b) Surgical patients admitted will have diagnostic testing performed according to the current pre-admission testing guidelines recommended by the Department of Anesthesia and Patient Care Services (PCS) policy #352.

All female patients between the ages of 12 - 54, who are to undergo any surgery at the Hospital, shall have recorded a serum and/or urine pregnancy test. A qualitative urine pregnancy (HCG) test is preferred. This test shall be performed at the Hospital Laboratory, and shall be recorded on their permanent record before surgery is performed. Exceptions shall include women who have had a hysterectomy, women admitted for missed abortions, or women admitted for repeat cesarean sections. Pregnancy testing shall be waived if patient is at risk for losing life or limb

A type and screen or crossmatch is ordered at the discretion of the surgeon based on the Maximum Blood Order Schedule guidelines. The Maximum Blood Order Schedule guidelines are based on the American Association of Blood Banks recommendations and upon joint considerations of the Anesthesia Section, the Surgery Department, the Laboratory Blood Bank.

The patients managed through Pre-Admission Testing scheduled for general anesthesia in the Hospital shall have a panel of electrolyte determinations taken under certain conditions:

- (1) History of insulin dependent Diabetes Mellitus
- (2) History of acute or chronic renal failure
- (3) Taking digitalis

- (4) Taking diuretics
- (c) Laboratory testing from other Joint Commission and/or College of American Pathologists accredited facilities is acceptable up to thirty (30) days prior to the actual surgical procedure as part of the pre-admission screening process following the Pre-Admission Testing guidelines. An official Laboratory copy must be presented at or prior to the pre-admission screening process and contain the following information:
 - (1) Birth date of the patient
 - (2) Full name of the patient
 - (3) Date the Laboratory test was performed

2.8 Other Diagnostic Tests Required

- (a) X-ray reports (interpretation) and the EKG strip with interpretation can be used if they are presented at or prior to the time of the pre-admission testing interview and contain the following information:
 - (1) Birth date of the patient
 - (2) Full name of the patient
 - (3) Date the diagnostic test was performed
- (b) The EKG interpretation is permissible if performed within six (6) months. The interpretation of the EKG must be performed by a board certified or eligible qualified Practitioner as is specified within the rules and regulations and on the medical staff at a TJC accredited hospital.
- (c) The Radiologist interpreting the radiologic testing must have active staff privileges at a Joint Commission accredited hospital.

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