The purpose of the Lucile Packard Children's Hospital Stanford (LPCHS) is to furnish quality medical care, treatment, and services to the patients it serves, to further the education of students of the health professions and of health professionals, and to promote research for the benefit of children and pregnant women.

The Medical Staff is responsible to the Board of Directors for the professional medical care performed at the Hospital and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional medical care are hereby adopted.

1. PATIENT TYPES AND ADMISSION OF PATIENTS

A. Description

LPCHS is a general acute care hospital that responds to the medical needs of acutely and chronically ill infants, children, adolescents, adults who have chronic illnesses unique in origin to childhood, and patients of any age who present themselves for reproductive care. In addition, the Hospital manages a set of specialty clinics located onsite and off-site. To facilitate the Hospital's management of its patient care programs, some patients may be referred to other more appropriate institutions for continuing care.

B. Definitions

Patient encounters at Lucile Packard Children's Hospital Stanford fall into three general categories: inpatient, emergency, and outpatient. These are based on the service provided as well as on specific regulatory requirements such as Title 22 of the California Code of Regulations and the Medicare Conditions of Participation.

1) Inpatient: An inpatient is a person who has been admitted to the hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight.

2) Emergency: Basic emergency medical service means the provision of emergency medical care. Members of the LPCHS Medical Staff may provide care at Stanford Healthcare (SHC).

A Medical Screening Exam (MSE) must be conducted by physicians or Qualified Medical Personnel (QMP), as approved by the Medical Executive Committee, to determine whether an emergency medical condition exists. A QMP is an individual who is licensed or certified and has demonstrated current competence in the performance of the medical screening exam.

In the Labor and Delivery Department at SCH, in addition to physicians, Registered Nurses (R.N.) who have been credentialed to perform a labor check utilizing standardized procedures approved by the Interdisciplinary Practice Committee or MEC, as well as Certified Nurse-Midwives ("CNMs") approved

by the MEC, are designated as QMPs and may perform MSEs provided they are acting within their scope of practice and under the appropriate physician supervision.

3). Outpatient: A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

a. Hospitalized Episodes

(1) Ambulatory Care Procedure: Ambulatory procedures, including, but not limited to, same-day surgeries, angiograms, bronchoscopies, cardiac catheterizations, and endoscopies, are generally invasive and require coding and abstracting by the Health Information Management Services (HIMS).

b. Other Outpatient Episodes/Services

(1) Clinic Visits: In the case of clinic visits, whether in person or virtual, diagnosis and other information related to the encounter are provided by the physician member of the medical staff with relevant approved privileges, who performs the examination or who is overseeing the activities of an allied healthcare professional.

(2) Diagnostic Services: Diagnostic services, such as laboratory and radiological studies and treatment such as chemotherapy, radiation therapy, and physical therapy, are performed based on the written order of a qualified physician, who is also responsible for providing the patient's diagnosis and other clinical justification for the test or therapy.

(3) Referred Specimens: These services are rendered when the patient does not present for service, but rather a specimen is sent by a physician office, hospital, or other institution for evaluation or consultation

C. Admission Criteria

Patients may only be admitted to LPCHS as an inpatient or accepted for outpatient hospital registration by a member of the Medical Staff with appropriate privileges who has been granted the privilege to admit patients to the Hospital in accordance with state law and criteria for standards of medical care established by the Medical Staff. Orders for admission and discharge of patients may be written by housestaff and by allied health professionals, including nurse practitioners and physicians, on behalf of the attending physician. All patients shall be under the direct care or supervision of a member of the Medical Staff.

1) Except in emergencies, no patient shall be admitted to the Hospital without a recorded provisional diagnosis. In the case of an emergency, such a diagnosis shall be recorded as soon as possible.

2) When patients are admitted to the Hospital for medical and/or surgical therapy or treated in the Clinic for diseases, including relapsed diseases, diagnosed on the basis of histological sections, cytology, peripheral blood, bone marrow aspirate or other specimens smears, and when the proposed therapy depends on the interpretation of those specimens, all such specimens and ancillary testing reports

required for interpretation of the specimens shall be submitted for formal written interpretation by Stanford Anatomic Pathology and Clinical Laboratory Services for confirmation of the diagnosis prior to initiation of therapy, except when urgent therapy is indicated.

3) The Medical Staff member shall be responsible at the time of admission for providing to the Nursing Supervisor, Security Services, and/or other appropriate personnel such information as may be necessary to enable the Hospital to protect the patient from self-harm and to protect other patients, staff, and visitors from possible sources of danger.

4) It shall be the responsibility of the Medical Staff member to report all cases of reportable diseases in accordance with the regulations of the California State Board of Public Health for the Control of Communicable Diseases, and LPCHS Infection Control Procedures and Policies.

D. Admission of Patients

1). Only those members authorized in accordance with the Bylaws of the Medical Staff may admit patients to the Hospital. The patient's Attending Physician shall execute, or cause to be executed, all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admitting and discharging of patients from the Hospital.

2). All patients admitted to LPCHS are considered part of the Hospital teaching service. Duly assigned medical students and Housestaff are expected to obtain and record initial histories and perform physical examinations, participate in patient care under the direction of the attending physician, and record progress notes in the medical record. Patients may be presented to the Department Head or designee on teaching rounds, but patient care decisions are the responsibility of the attending physician.

3). Except in emergencies, all patients or their legally authorized representatives shall sign the Core Data – Terms and Conditions of Service consent form.

2. MEDICAL RECORDS

A. Definitions:

A medical record shall consist of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Department. The information contained therein, and any other patient-specific information, shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access

Access to confidential materials by members of the Medical Staff and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or some other appropriate authorized activity. This requirement applies irrespective of the

form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored.

a Traditional Paper Chart: legal record prior to June 2002. These charts are stored off-site and are retrievable by HIMS.

b. Scanned Record: legal record from July 2002 to September 9, 2005. Any and all (electronic and/or handwritten) documents generated during a patient's stay are scanned and indexed.

c. From September 10, 2005, to May 4, 2014: LINKS was the LPCH clinical database that stored electronic results (lab, radiology, transcription, pathology orders), electronic clinical documentation by all disciplines, interfaced/imported results or reports, and scanned documents.
d. From May 5, 2014, to present: Epic is the LPCHS electronic health record system (EHRS) that stores the complete patient medical record, and additional information related to the patient's healthcare encounter at LPCHS.

C. Required Medical Record Elements

Elements required in a medical record include identification data; appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology, and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives.

D. Documentation Rules

1). Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record shall be as stated in the Hospital's Policies and Procedures governing medical records.

2) Entries must be legible, authenticated (signature, name) and dated and timed by the individual making the entry.

3) Source documents and other appropriate information should be used when necessary, in documenting patient care summaries or other similar notes in the medical records

4). The attending physician shall be responsible for the timely preparation and completion of the patient Medical Record. Medical Records entries must be authenticated within 14 days following the patient's discharge.

5). Medical students must include identification of student status when documenting in the medical record. Any types of medical student notes reviewed and cosigned by supervising providers will be part of legal medical record.

6). All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed using the 24-hour clock. The following entries should be timed using 24-hour clock:

a. Orders.
b. Post-operative notes immediately following surgery.
c. Administration of medications.
d. Restraint application and removal.
e. Anesthesia notes immediately prior to induction.

7) Symbols and abbreviations may not be used on the face sheet or in the final diagnosis.

8) A list of ***unapproved*** symbols and abbreviations has been approved by the Medical Staff. Use of ***unapproved*** symbols and abbreviations has the potential to negatively impact patient care. No order for medications will be accepted if the order contains a symbol or abbreviation on the ***unapproved*** list until the physician has been contacted for order clarification. The Pharmacy and Therapeutics Committee will monitor compliance with these requirements.

9) A clinic note should be dictated, or electronically entered for each visit or consult within 48 hours of the encounter. All encounters need to be completed within 14 days of the visit.

10) Effective 2021, outpatient New and Established patient clinic visit documentation, must conform with the Centers for Medicare and Medicaid Services (CMS) requirements (regardless of payer), including:

a. Chief complaint or reason for visit
b. Medically appropriate history
c. Medically appropriate exam
d. Assessment and plan
e. Time (if billing based on time)

All ***other*** outpatient clinic visit documentation (i.e., consultation), must conform with the CMS 95 or 97 Documentation Guidelines for Evaluation and Management Services (regardless of payer), including:

a) Chief complaint or reason for visit
b) History of present illness
c) Review of systems and pain evaluation
d) Past family and social history
e) Physical examination

Assessment and plan

11) A focused medical assessment must be done prior to or at the time of an invasive procedure that does not require anesthesia or moderate sedation.

a. Presenting diagnosis/condition
b. Description of symptoms
c. Significant past medical history

d. Current medications
e. Any drug allergies
f. Indications for the procedure
g. Focused physical exam as indicated
h. Proposed treatment or procedures

12) Orders:

a. Orders for ancillary and diagnostic services should include the diagnosis (ICD-10 code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service / treatment.

b. An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of nomenclature and ***unapproved*** abbreviations in medication orders, both generally and for specific types of medications.

c. For treatment orders, provide explanation as appropriate.

13) A telehealth visit is a prescheduled visit. Any prescheduled visit related to a telehealth visit, even if it is converted to a telephone call, is documented in the medical record. A phone call can occur at any time; however, it should be distinguished from a failed telehealth visit that converts to a phone call.

14) All clinical correspondence with patients must be maintained within the medical record.

15) A problem/summary list must be initiated by the third visit to an ambulatory care clinic.

a. Patients will have a Diagnosis and Medication Summary List in their medical records. The Problem/Summary List will contain significant and on-going medical diagnosis/conditions, history of significant surgical and invasive procedures, allergies, current medications, and date of last revision. The Problem/Summary List will be maintained as part of the permanent medical record.

b. The Summary List will be revised when the medical condition/diagnosis changes, medications are discontinued or changed, the patient has undergone additional significant surgical procedures and/or when there is a change in allergy status.

16) Education and instructions provided to the patient and family should be documented in the record.

E. Timeliness Requirement for Documentations

1) General Inpatient

a. H&P – the H&P must be completed within 30 days before admission or within 24 hours after admission.
b. Discharge Summary – the electronic discharge note must be completed before the patient is discharged, the full discharge summary must be dictated, signed or documented electronically within 14 days of discharge.
c. Verbal Orders/Telephone Orders –all medication verbal orders must be signed within 48 hours, whether Computerized Physician Order Entry (CPOE) or written on paper form. All other verbal orders must be signed within 14 days of discharge.

2) Clinic Patients

a. Clinic note should be completed within 14 days of visit.

3) Inpatient/Outpatient Procedures

a. Operative Report – the operative report must be completed within 24 hours of surgery.
b. Immediate Post-Operative Note – the Immediate Post-Operative Note must be completed prior to the patient moving to the next level of care.
c. Updated H&P – if the H&P is not completed within 24 hours of the procedure, the pre-op H&P must be updated prior to surgery for a procedure requiring anesthesia services

F. Attending Physician Counter-signature Requirements for Documentations

1) For inpatients, the attending physician must review and sign the History and Physical, the immediate Post-Operative Note, Operative report, Consultation, Transfer Summary, and Discharge Summary.
2) The following inpatient documents should be reviewed and signed by attending physician as outlined below:

Inpatient Note Type	**Resident/Fellow**	**PA**	**NP**
Interim Summary	Optional	Optional	Optional
Progress Note	Yes	Yes	Yes
Procedure Note (bedside)	Optional	Optional	Optional
Confidential Note	Yes	Yes	Yes

The following outpatient documents should be reviewed and signed by attending physician as outlined below:

Outpatient Note Type	**Resident/Fellow**	**PA**	**NP**
Clinic Notes to be used as H&P	Yes	Yes	Yes
Progress Note (dictated or entered)	Yes	Optional	Optional

Confidential Note	Yes	Optional	Optional
Procedure Note (minor)	Yes	Optional	Optional
Psychiatric Note	Yes	Optional	Optional

When notes are completed by a PA or NP, the attending physician must review and sign the notes if the attending physician intends to bill for professional services in association with the shared visits.

3. CONSENT AND DISCLOSURE

A. Informed Consent

Unless an emergency exists, no care or treatment shall be rendered to any patient in the Hospital, Emergency Department, or Clinics without a written consent signed by the patient or their properly designated representative (see - Informed Consent Policy)
In an emergency, where immediate services are required to alleviate or prevent severe pain, disability or death and consent from the patient cannot be obtained, the Physician recommending treatment to the patient shall follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable.
Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment which is considered complex based on medical judgment, and includes, but is not limited to the following situations:

1. Operative procedures
2. Invasive procedure which has the potential to cause serious risks and adverse reactions
3. Sterilization Consent
4. Research on Human Subjects
5. Blood transfusions or other use of blood products
6. Planned use of moderate sedation
7. Electroconvulsive therapy

The informed consent discussion should include at least information about the specific procedure or treatment, the reasonably foreseeable risks and benefits of the treatment, and the reasonable alternatives for care and treatment. Further information on what is required in the discussion and what must be documented is found in the Administrative Manual policy *Informed Consent*.

In all surgical procedures, the physician in whose name the permission for the operation is obtained shall participate in person or as a member of the operating team and shall be present during the critical portion(s) of the procedure. Such participation shall not be delegated without the informed consent of the patient or the patient's properly designated representative.

B. Disclosure of Unanticipated Outcomes and Medical Errors

Definitions*:*

The institution has a policy of transparency of disclosure of unanticipated outcomes or medical errors to patients. The organization focuses its efforts on Serious Safety Events (SSE). The Healthcare Performance Improvement, LLC (HPI) definition of SSE includes events in which there is deviation from best practice care, causation, and significant patient harm. All SSEs are disclosed to the family as soon as possible.

Disclosure

The attending physician responsible for the patient's care, or their designee as appointed by the President of the Medical Staff or Chief Medical Officer (CMO), or Chief Quality Officer shall serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian. The person designated as the primary communicator with the patient/family shall document in the progress notes of the patient's medical record what was communicated to the patient/family and any response or other discussion.

C. Sterilization

Sterilization is to be performed only in accordance with applicable federal and State law as well as policies and procedures approved by the Medical Executive Committee.

4. RESEARCH

A. Any research project conducted in the Hospital involving human subjects must be approved by the Administrative Panel on Human Subjects in Medical Research (the Investigational Review Board or "IRB") of Stanford University School of Medicine.

B. All research projects must be conducted in accordance with the Medical Staff Policy on Clinical Research. Confidentiality is maintained in accordance with SHC / LPCHS HIPAA Research policy.

5. ASSESSMENT (TYPES AND SERVICE)

A. Definitions

1) Complete H&P: All patients admitted to the hospital or registered for outpatient surgery will have a complete H&P documented in the medical record. The H&P will conform to the following requirements to ensure quality of care and comply with The Joint Commission, CMS and Title 22 regulations:

a. A medical history and physical examination for each patient is completed within no more than 24 hours after inpatient admission, but prior to surgery or a procedure requiring anesthesia services by a practitioner privileged to do so.

b. An H & P that is greater than 30 days old is invalid.

c. If a medical H & P exam has been completed (done) within 30 days of registration or inpatient admission, it must be updated with any changes in the patient's condition within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. If no changes have occurred, the absence of change must be documented.

d. If an assessment has been done within 30 days of outpatient surgery, it must be updated within 24 hours before surgery noting any changes in the patient's condition. If no changes have occurred, the absence of change must be documented. The update must be done prior to surgery requiring anesthesia services.

e. The H & P requirement does not apply for Emergency Surgery; however, it must be done as soon as possible after surgery.

B. Admission/Registration Type or Service:

1) Inpatient – Interval H&P will be required if there are changes in the medical history or physical examination. For inpatient surgery, an H&P less than 30 days old must be supplemented by an interval H&P. If there is an H&P less than 24 hours old in the chart, the interval H&P will not be required. Inpatients with a length of stay greater than 30 days are required to have a new H&P dictated or electronically entered within 24 hours prior to surgery.

2) Outpatient—Requires an H&P less than 30 days old and an interval H&P within 24 hours of surgery indicating any changes in medical history or physician examination since the most recent H&P was completed. If no changes have occurred, a note stating that no changes have occurred and that the indications for surgery remain, must be included. All documentation must be completed within the designated timeframe, **prior** to the operative procedure.

3) Sedation and Anesthesia Care: In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a pre-anesthesia assessment.
4) Infusions/Day Hospital Care: An H&P or clinic note less than 6 months old from the ordering provider or their designee must be present in the medical record for patients of providers utilizing the SSU.

C. Complete H&P:

1). A complete H&P has the following components: History, physical examination, assessment, and treatment plan as indicated.

a. History includes:

(1) Presenting diagnosis/condition (chief complaint/reason for the visit)
(2) Description of symptoms
(3) Current medications
(4) Any drug allergies
(5) Significant past medical & surgical history
(6) Review of systems
(7) Significant family history
(8) Psychosocial status
(9) Nutritional evaluation (if GI, pediatrics, or elderly)
(10) For surgery or invasive procedure requiring moderate sedation or anesthesia:

(a) Indications
(b) Proposed procedures
(c) ASA Classification

(11) If pediatrics:
(a). Immunizations
(b). Neonatal history for pediatric patients (if applicable)

b. Physical examination (should include as appropriate an examination of body areas/organ systems):

(1) Vital signs
(2) Cardiovascular system
(3) Respiratory systems
(4) Neurological system
(5) Gastrointestinal system
(6) Eye
(7) Ear, Nose and Throat (ENT)
(8) Genitourinary system
(9) Musculo-skeletal
(10) Skin
(11) Psychiatric
(12) Hematologic/lymphatic/immunologic

c. Assessment

d. Treatment Plan

D. Interval H&P

The interval H&P must update any components of the patient's current medical status, regardless of whether or not there were any changes, and confirm that the necessity for the procedure is still present. The interval H&P must state that the provider has examined the patient and reviewed the H&P and state that there is additional information or there is no change since the H&P was done.

E. H&P for patients of non-physician medical staff

1) Patients of a dentist, podiatrist, or clinical psychologist must have a medical history and physical examination (H&P) signed by a physician with hospital admitting privileges or Advanced Practice Provider (APP). APPs inclusive of certified nurse midwives, nurse practitioners, physician assistants are authorized to complete H&Ps without a co-signing physician.

2) Orders issued by anyone other than a member of the Medical Staff, APP working under protocols approved by the Interdisciplinary Practice Committee (IDPC), or house staff must be cosigned by a licensed physician prior to implementation. The follow exceptions apply:

a. Verbal and telephone orders (as described below).
b. Orders under protocols approved by nursing, medical and pharmacy leadership and in compliance with CMS requirements.

Written orders are reviewed by the attending physician or advanced practice provider (APP). The history and physical examination must be dictated or electronically entered. All history and physical examinations must be signed by an attending physician or an APP. Daily progress notes may be done by residents, physicians, or APPs.

6. PLANNING CARE, TREATMENT AND SERVICES

A. Orders

1) All orders for treatment must be entered into the electronic health record using Care Provider Order Entry (CPOE) whenever possible.

2) Exceptions to this rule include:
   a. units where CPOE is not available
   b. during codes
   c. electronic health record downtimes.

   In these exceptional situations written orders for treatment must be in writing, dated and timed, and signed by the issuing practitioner and should include the issuing practitioner's pager number.

3) Except for verbal and telephone orders (as described below), orders issued by anyone other than a member of the Medical Staff, Nurse Practitioners, Physician Assistants (working under protocols approved by the Interdisciplinary Practice Committee, or IDPC), or housestaff must be cosigned by a licensed physician prior to implementation.

4) For patients in the preoperative area, licensed nursing staff may initiate electronic orders which have been signed by physicians within 30 days of admission as described in the patient care policy.

   The use of standing orders must be documented as an order in the patient's medical record and authenticated by the practitioner responsible for the care of the patient, as the regulations of 42 CFR §482.23 (c)(2) and §482.24 (c)(1) require, but the timing of such documentation should not be a barrier of effective emergency response, timely and necessary care, or other patient safety advances. We would expect to see that the standing order had been entered into the order entry section of the patient's medical record as soon as possible after implementation of the order (much like a verbal order would be entered), with authentication by the patient's physician.

B. Verbal/Telephone Orders

Verbal/telephone orders shall be issued only by a member of the Medical Staff, Nurse Practitioners, Physicians Assistants, or member of the housestaff.

Verbal/telephone orders shall be issued only if the circumstances are such that an immediate order is required, and it would be impractical for the prescriber issuing the order to do so using the electronic medical record CPOE.

1) Verbal/telephone orders will be taken by the appropriate staff in the following situations:

   a. Emergency.
   b. If the physician/clinician is performing a procedure.
   c. If the physician/clinician does not have access to the electronic health record.

2) Verbal or telephone orders require a verification "read-back" of the complete order by the person receiving the order after the order is entered in the electronic health record. Any decision support alerts must be communicated to the ordering provider before the order is activated. In emergency situations where the issuing provider is unable to remain on the phone, the receiving staff will write out the order and read it back. The issuing provider must provide a phone or pager number so that they can be reached by the receiving personnel to communicate any decision support alerts. If electronic order entry is not available, the receiver of the order will write out the complete order and then read it back to the ordering provider.

3) Verbal orders must be signed within the required timeframe by the provider. Verbal order entered electronically by the staff will be signed electronically by the issuing provider in the electronic health record. If the order is paper based, these will be scanned using the document imaging system, and the document will be forwarded to the provider's Inbox in the electronic health record to be signed electronically.

4) Medication verbal/telephone orders must be signed within 48 hours and signed by the prescribing practitioner or by attending or covering physician on an infrequent basis (see LPCHS Physician Order Policy).

7. MEDICATIONS

A. No medications shall be administered except by licensed or lawfully authorized personnel and upon the order of a person lawfully authorized to prescribe or furnish such medications. Those categories of staff authorized to administer medications include:

1) Licensed physicians

2) Licensed dentists and podiatrists

3) Supervised housestaff

4) Registered nurses

5) Licensed vocational nurses (except for I.V. medications)

6) Hemodialysis technicians

7) Registered pharmacists

8) Allied health professionals within the scope of their licensure

9) Respiratory care practitioners

B. Medication orders shall include the name of the drug, dosage, frequency of administration, date, duration of therapy if known, route of administration, and the prescriber's signature. All medication orders shall be reviewed by a licensed pharmacist prior to administration of the first dose for appropriateness, unless the administration of a dose is an urgent situation in which the resulting delay would harm the patient or if a licensed independent practitioner controls the ordering, preparation, and administration of the medication. The requirements for Verbal Orders are Section 6.B.

C. Orders which need to be co-signed.:

1) Medical students or advance practice provider (APP) students-- orders written by medical students or APP students must be reviewed and co-signed by a licensed physician or APP prior to administration.

2) Psychologists -- behavioral therapy orders may be written by psychologists within the scope of their licensure. Medication orders must be co-signed by the attending physician.

3) Clinical nutritionists -- nutrition orders may be written by clinical nutritionists, after consultation with the attending physician. The orders will indicate the physician's name and be signed by the nutritionist. The physician shall co-sign the order within 48 hours.

D. Order sets may be ordered in the electronic health record or using a preprinted order set if CPOE is not available.

E. Standing Orders for medications must be documented as an order in the patient's medical record and authenticated by the practitioner responsible for the care of the patient, as required by 42 CFR §482.23 (c)(2) and §482.24 (c)(1). The timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety goals. Standing Orders must meet the following conditions:

1) They must identify the circumstances under which the drug is to be administered.
2) They must specify the types of patients and medical conditions for whom the standing orders are intended.
3) The Standing Order must be - initially approved by the Pharmacy and Therapeutics Committee or its equivalent and are reviewed at least annually by that committee.
4) The Standing Orders are specific as to the drug, dosage, route and frequency of administration.
5) Adhere to guidelines in the Order Entry by Non-Provider's Policy.

F. Medications brought by or with the patient to the Hospital shall not be administered to the patient unless all of the following conditions are met:

1) The medications have been specifically ordered by the patient's licensed Provider, and the order entered in the patient's medical record. The order must

include the drug name, strength, frequency, and route. The order must state that the patient's own supply of medications should be used.

2) The Pharmacist shall positively identify the medication, examine it for expiration or signs of physical deterioration, and if necessary, re-label and/or re-package the medication.

3) The medication is not in the Hospital Drug Formulary or is not available from the LPCH Pharmacy.

4) Hemophilia patients may bring in their own supply of factor replacement to insure continuation of therapy with the most appropriate product from an FDA-approved manufacturer.

5) Any treatment of Ambulatory Services should be referenced in the Ambulatory Policy Manual located on the intranet.

G. If a change in the Clinical Service and/or physician responsible for the patient occurs, all orders for the patient shall be reviewed by the new Service and/or physician and reaffirmed or discontinued via written order in the patient chart.

H. Automatic Stop of Medications

1) If a prescriber orders drugs for a specific duration of therapy, the medication will be administered for the specified duration of therapy. There will be no automatic stop.
2) If a prescriber orders drugs for immunosuppression, seizure disorders, or metabolic supplementation, there will be no automatic stop.
3) If a prescriber orders drugs without a specific duration of therapy, the medication order will have an automatic stop of 30 days unless it is a drug listed below:

   a. Unfractionated heparin drips with concentration greater than 5 units/ml will have an automatic stop of 7 days.
   b. Controlled substances will have an automatic stop of 7 days. Exception: orders for phenobarbital or clonazepam in the management of seizures will not have an automatic stop.
   c. Ketorolac will have an automatic stop of 5 days.
   d. Activated Recombinant Factor VIIa (7a) will have an automatic stop of 7 days.
   e. Dornase alfa orders will have an automatic stop of 48 hours for all patients except those with a diagnosis of cystic fibrosis. (Dornase alfa orders for patients with cystic fibrosis will have an automatic stop of 30 days.)
   f. Aminoglycosides and vancomycin will have an automatic stop of 7 days.
   g. PRN IV potassium chloride orders will have an automatic stop of 7 days.

4) If medications are not renewed prior to the stop date, they will be considered expired and must be renewed.
5) If a medication is to be given to the patient for a duration that exceeds the automatic stop order times, the duration must be indicated.

I. Medications used shall be only those listed in the LPCH Drug Formulary except for:

1) Non-formulary medication for which an acceptable alternative from the formulary is not available.

2) Those employed in research protocols approved by the Stanford University Medical Center Administrative Panel on Human Subjects in Medical Research (Investigational Review Board or IRB). Investigational medications shall be used in accordance with applicable state and federal laws and regulations, as well as policies recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee.

3) Those employed for purposes of direct therapeutic benefit to a particular patient in an emergency, when approved by the President of the Medical Staff or CMO.

8. PROVIDING CARE, TREATMENT AND SERVICES

A. Daily Care of Patients

A hospitalized patient must be seen by the attending physician or a member of the housestaff, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note shall be written on each patient daily in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status at the time of observation

B. Consultations

1). It is the responsibility of the Medical Staff through the Chiefs of Services and Medical Directors to see that members obtain consultations when appropriate and when requested by the Chiefs of Services, Medical Directors, or President of the Medical Staff. Services may specify the minimum criteria as to when a consultation is required. In addition to any criteria for consultation in the Clinical Service Rules and Regulations, a consultation is obligatory in the event that the patient requires a scope of care that is outside the expertise and/or clinical privileges of the attending practitioner, or if there is some uncertainty as to the appropriate course of treatment for a given patient. Consultations shall show evidence in the medical record of the consultant's review of the patient's record, his/her/their pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. In case of emergencies, a nurse is authorized to seek appropriate medical consultation if the responsible attending or Housestaff physician is not available.

2). Two types of consultations may be obtained. Each involves different levels of patient care management and overall responsibility on the part of the consultant.

a. "Consultation only" is ordered when the attending physician wishes the consultant to review the patient's records and pertinent findings to render an opinion and make treatment recommendations. The consultant is not directly involved in patient management, does not place orders in the chart, or have overall responsibility for the patient's care.

b. "Consultation and management" is ordered when the requesting attending physician wishes the consultant to place orders in the chart and participate directly in patient care management.

3). Patients who exhibit significant psychiatric illness, with acute exacerbation of symptoms or new onset of symptoms, while hospitalized will be referred for an evaluation by a psychiatrist on the medical staff as outlined in the Service Rules and Regulations and hospital policy, if the attending physician believes that management of the patient is beyond their scope of practice. Patients with alcohol/drug abuse/intoxication/dependence will be referred for psychiatric evaluation if the attending physician believes management of the patient is beyond their scope of practice. Consultation will involve diagnostic evaluation, acute management suggestions and assistance, and referral for outpatient treatment as indicated.

C. Sedation and Anesthesia

1). A pre-anesthesia evaluation must be completed prior to Sedation and Anesthesia:

a. History:
   (1) Medical History performed by a physician with a review of systems (specific to cardiovascular disease).
   (2) Any adverse or allergic drug reactions with anesthesia or sedation
   (3) Level of consciousness
   (4) NPO status
   (5) Airway assessment
   (6) ASA classification

b. Physical Assessment:
   (1) Prior to induction update vital signs
   (2) Physiological monitoring is measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room record.

c. Brief description of the planned procedure(s).

d. Planned anesthesia type, including risks, benefits, and alternatives.

e. Re-evaluation must be done immediately prior to moderate or deep sedation use and before anesthesia induction.

2) A post anesthesia follow-up report by the individual who administered the anesthesia must be written within 48 hours after surgery.
   (a) Recorded on the Anesthesia Assessment Form.
   (b) Should specifically document any intra-operative or postoperative anesthesia complications.

The ideal state process includes the plan that the postop Anesthesia note will be completed after handoff of care (OR to ICU), with the notation that the patient is no longer under anesthesia care. Additional postop notes can be done when warranted, but this initial note will be the expectation.

The CMS Post-Anesthesia Evaluation requires the following elements:

- Respiratory function (rate, airway patency, and O2 sat)
- Cardiovascular function (pulse rate and BP)
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Perioperative hydration

D. Operative Care of Patients

1) The Immediate Post Op Note shall be completed immediately following surgery (inpatient or outpatient) before the patient transitions to the next level of care.

2) An operative report must be dictated or electronically entered for transcription within 24 hours after surgery. The report should contain:

a. Pre-op Diagnosis
b. Post-op Diagnosis
c. Operations performed
d. Principal Surgeon, assistant surgeons, type of anesthesia administered.
e. Intra-operative findings
f. Description of the procedures performed
g. Intra-operative complications, if any
h. Tissue, body fluids or hardware submitted to Pathology

3) The writing or dictation of reports required by this section may be delegated to a member of the house staff only if the Teaching Physician was present and directly participating during the entire surgery or procedure. This statement must be clearly documented by either the resident/fellow or by the Teaching Physician. If the resident provides the documentation, the Teaching Physician must countersign the entry.

9. COORDINATING CARE AND TREATMENT

A. Discharge

1) Patients shall be discharged only on the order of the responsible licensed independent practitioner. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible practitioner shall be obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For pediatric patients that have been in the Hospital for a period of more than 48 hours, the patient's discharge summary shall be documented within 48 hours of discharge. For patients with a stay less than 48 hours a discharge note is required to be electronically documented in EPIC. A final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. For the obstetrical vaginal delivery patient who has a stay longer than 4 days, or for the

obstetrical or Cesarean section patient who has a stay longer than 5 days, a discharge summary is required. All inpatient deaths shall have a discharge summary regardless of length of stay.

2) Should a patient leave the Hospital against medical advice, this shall be documented in the patient's medical record and the patient should be requested to sign the appropriate release form.

3) Discharge Summary

a. The Discharge Summary can be documented.
b. The content of the discharge summary should be consistent with the rest of the record and include:

(1) Admitting date and reason for hospitalization.
(2) Discharge date.
(3) Final diagnoses.
(4) Succinct summary of significant findings, treatment provided and patient outcome.
(5) Documentation of all procedures performed during current hospitalization and complications (if any).
(6) Condition of patient upon discharge and to where the patient is discharged.
(7) Discharge medication, follow-up plan, and specific instructions given to the patient and / or family, particularly in relation to activity, diet, medication, and rehabilitation potential.

B. Patient Death

In the event of death, the patient shall be pronounced dead by a licensed physician. The physician pronouncing the death shall be responsible for determining if the death is reportable to the County Coroner's Office and shall make such reports in accordance with the applicable California laws. The body shall not be released from the Hospital until an appropriate entry by a licensed physician has been made and signed in the patient's medical record. Policies with respect to the release of bodies shall conform to California law.

It is the policy of Lucile Packard Children's Hospital Stanford to report all deaths of all patients, including newborns (greater than/equal to 32 weeks gestation at time of death and greater than/equal to 500 grams), to the organ procurement agency, Donor Network West at (800) 55-DONOR. This referral should be made at or near the time of cardiac death or imminent brain death. Lucile Packard Children's Hospital Stanford staff will work in collaboration with Donor Network West to make sure identified, potential donors are referred appropriately. In cases of organ donation after circulatory death (DCD), refer to: Patient Care Policy: Organ Donation After Circulatory Death.

10. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

A. Autopsy

Every clinician is expected to request written permission for autopsies from the legally authorized person for each perinatal, pediatric, or obstetric death (see Autopsy Policy). This request and the response received are documented in the physician's progress notes. Autopsies shall be performed by the Stanford Hospital and Clinics Pathology Department. The Autopsy Consent form must be appropriately filled out and signed by the appropriate next of kin and clinician. Verbal/recorded consent can also be obtained. Written/verbal consent must be provided to the Autopsy Service at the Stanford Hospital and Clinics Pathology Department. Provisional Anatomic Diagnoses shall be recorded in the medical record within forty-eight (48) hours and the complete report should be made part of the medical record within sixty (60) days. Information on the time and date of the autopsy may be obtained by calling Autopsy Services at Stanford Hospital and Clinics. All physicians are encouraged to attend autopsies on their patients.

It is the responsibility of the physician to notify the coroner of cases suspected of coming under the coroner's jurisdiction, or at the discretion of the clinician, per the deceased patient management policy. The coroner should also be notified in cases of suspected child, spouse, or elder abuse.

B. Patients at Risk to Harm Self (including suicide) and/or Others

For the protection of patients, the medical and nursing staff, and the Hospital, the following standards are to be met in the care of the patients at risk of harm to self or others:

1) Patients will be evaluated by social work and/or psychiatry and the response will be implemented per the Emotionally Distressed/Suicidal Patient Management Policy.

C. Suspected Medical Child Abuse

For the protection of patients, the medical and nursing staff, and the Hospital, the following standards are to be met in the care of patients suspected of being the victims of Medical Child Abuse (also known as Factious Disorder Induced in Another, Munchausen Syndrome by Proxy):

1) Psychiatric consultation shall be obtained as soon as possible after care is assumed. This includes cases lacking physical evidence (e.g., positive toxicology screen for cathartics), but where the behavior of the parents and/or child and the nature of the medical symptoms suggest the induction of illness or fabrication of symptoms

2) Consultation by the SCAN Child Abuse and neglect team should be obtained as soon as familial behavior or medical symptoms suggest suspicion for induction of illness or fabrication of symptoms.
3) Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders.

D. Restraints

A restraint can only be used if needed to ensure the immediate physical safety of the patient, a staff member, or others when less restrictive interventions have been determined to be ineffective and must be discontinued at the earliest time possible. Except for in emergency situations, a Licensed Independent Practitioner (LIP) responsible for the care of the patient orders restraints prior to application of restraint. LIPs must have a working knowledge of hospital policy on restraint use before ordering restraints. Orders for the use of restraint must never be written as a standing order or on an as needed basis (PRN).
The attending physician must be consulted as soon as possible if the attending did not order the restraint.

The order for restraint must comply with the medical staff approved Hospital policy on restraints. Standards for restraint care exist in policy for Restraints.

When restraint is used for the management of violent or self-destructive behavior, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a LIP, and every 24 hours thereafter if the patient is still in restraints to evaluate:

1) The patient's immediate situation
2) The patient's reaction to the intervention
3) The patient's medical and behavioral condition
4) The need to continue or terminate the restraint

E. Organ and Tissue Donation

Members of the Medical Staff are expected to follow the LPCH Protocol for Identifying Potential Organ and Tissue Donors. The Protocol provides that any deceased patient's next of kin or other legally authorized individual shall, at or near the time of notification of death, be asked whether the deceased was an organ donor or if the family is a donor family.

F. Tissue Specimens

Any specimen removed in an operative procedure or embryo/fetus delivered at LPCH Stanford may be sent to the Pathologist who shall make such examination as they deem necessary to arrive at a diagnosis. Refer to the Department of Pathology policies for a detailed description of exceptions (e.g., "Exceptions to The Policy That All Anatomical Parts, Tissue And Foreign Objects Removed By Operation Are Sent To The Department Of Pathology" and "Policy for Gross Only Specimens"). The pathologist's signed report shall be made a part of the patient's medical record.

11. TRANSFER OF PATIENT

If the attending physician transfers the care of a patient to another LPCH Medical Staff member, the outgoing physician shall appropriately communicate the transfer of care and responsibility to the new attending physician.

12. DEPARTMENT POLICIES AND PROCEDURES

Each Department may develop policies and procedures to be administered routinely to all patients admitted to their Service, which must be approved by the Medical Executive Committee. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be administered to all patients admitted to the Hospital. Where department and medical staff rules appear inconsistent, medical staff rules will supersede departmental rules.

13. CONFLICT OF CARE RESOLUTION

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about the patient¹s condition that they believe are not being adequately addressed or they have concerns about decisions being made in the care of the patient.

The chain of command involves administrative and clinical lines of authority. The lines of authority are established to ensure effective conflict resolution in patient care situations. The concerned member of the team should express their concerns to their immediate supervisor. If they still feel the issue is not adequately resolved, they should ask to speak to the supervisor's manager up the chain of command.

In all cases, the final authority in the chain of command on patient care decisions shall rest with the President of the Medical Staff or the Chief Medical Officer or their designee.

14. HOUSESTAFF SUPERVISION

All residents are supervised by the attending physician with appropriate clinical privileges and have regular evaluations of their performance while working at the Hospital. These evaluations are prepared by the attending physician and any performance issues are handled by the residency director in conjunction with the attending physician. Evaluations are based on the learning objectives of each rotation. Medical Staff members who serve as housestaff supervisors must be licensed independent practitioners and must hold clinical privileges that reflect the patient care responsibilities given to the residents.

Written orders are reviewed by the attending physician. The History and Physical must be dictated or electronically entered. All History and Physicals must be signed by the attending physician. Daily progress notes are written by the resident and attested to by the attending physician.

All residents are supervised and evaluated in accordance with the Hospital policy on Supervision of House Staff, the Housestaff Manual, and all policies of the Stanford Hospital and Clinics Housestaff Services Department.

A mechanism exists for effective communication between the Graduate Medical Education Program and the medical staff and governing body.

15. CONFIDENTIALITY

All members of the Medical Staff, Allied Health Professionals associated with that staff, and their respective employees and agents, shall maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by LPCHS or by business associates of LPCHS, in accordance with any and all privacy and security policies and procedures adopted by LPCHS to comply with current federal, State and local laws and regulations, including, but not

limited to, the HIPAA Privacy Regulations. Protected Health Information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with LPCHS's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff within the facility who has responsibility for THAT patient's care. This applies to general patients, psychiatric patients, and substance abuse patients as defined by the California Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996.

All Protected Health Information contained within any computer system, regardless of location, is considered confidential. Members of the Medical Staff who have access to this information are expected to maintain strict confidentiality, to protect the information from dissemination unless necessary for patient care purposes, and to use the information for patient care activities only.

Unauthorized use and/or access to Protected Health Information contained within any computer system by members of the Medical Staff may be grounds for disciplinary action. Such unauthorized use of, or access to, Protected Health Information will be reported to the Head of the Department to which the member is assigned.

Approvals:

LPCHS Medical Executive Committee	3/07, 12/08, 11/09, 12/12, 2/20, 5/21, 8/22, 9/23. 9/24
LPCHS Board of Directors	3/07, 12/08, 02/10, 02/11, 1/14, 2/20, 5/21, 8/22, 9/23. 9/24
Administrative Edits made to use of EMR.	Added "dictated or electronically entered"; Oct 2012, 4/2020