MEDICAL STAFF
ADMISSION AND DISCHARGE OF PATIENTS

POLICY:

1. The Hospital shall accept patients for care and treatment of patients requiring medical care and services approved by the Hospital Board of Directors. Patients with the following conditions will be admitted or transferred to an appropriate facility as follows:

   (a) **Contagious diseases** - when a patient with a contagious disease requires hospitalization, such patient shall be isolated and treatment provided in accordance with Hospital policies and in such a manner as to provide a safe environment for patients and to prevent the spread of communicable disease and infections in the Hospital.

   (b) **Mental Illness** - extremely combative or emotionally disturbed patients will not be admitted if the attending physician determines that the admission of such patient will adversely affect other patients or personnel in the Department of Psychiatry. In the event of an emergency, such patients may be admitted and cared for only until such time as they can be transferred to an appropriate facility.

   (c) **Alcoholism** - patients suffering from acute alcoholism and/or related illness may be admitted to the Hospital for treatment of their acute condition. A family member should be encouraged to stay with the patient. Patients requiring long term treatment, detoxification, or sobering up, should not be admitted unless they have an acute medical problem which requires attention. Such patients should be referred to an institution which has appropriate staff and facilities as soon as the acute medical problem is rectified.

   (d) **Drug Addiction** - patients requiring long term treatment for drug addiction shall not be admitted.

2. A patient may be admitted to the Hospital only on written order of a practitioner with appropriate clinical privileges granted by the Board of Directors. A patient admitted on a written order by a practitioner requiring a collaborative or supervisory agreement will be deemed to have been admitted by his responsible
supervisory or collaborating physician. This physician or back up physician will
countersign admission orders within 24 hours. At the time of admission or prior
to discharge, the admitting practitioner will certify the inpatient admission or
inpatient services are ordered in accordance with Medicare regulations
governing the order. This includes certification that inpatient services are
reasonable and necessary, in accordance with the two-midnight benchmark
under CFR 412.3(e).

3. All practitioners admitting patients shall be responsible for providing such
information as may be necessary to assure the protection of other patients and
personnel from those who are a source of danger from any cause whatsoever.
All practitioners are required, on admission of a patient, to provide provisional
diagnosis in accordance with standard nomenclature.

4. A member of the Medical Staff or appropriate privileged practitioner shall be
responsible for the medical care of each patient in the Hospital, 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 the
referring practitioner and to relatives of the patient. Whenever these
responsibilities are transferred to another practitioner, a note covering the
transfer of responsibility shall be entered on the order sheet of the medical
record.

5. All practitioners admitting patients shall be responsible for indicating to Access
Management whether the requested admission is to be classified as an
inpatient, observation, or outpatient therapeutic services in accordance to the
standards of The Centers for Medicare and Medicaid Services.

6. In any emergency case in which it appears the patient will have to be admitted
to the Hospital the practitioner shall, when possible, first contact the Access
Management to ascertain whether there is an available bed.

7. A patient presenting on an emergency basis who does not have a personal
practitioner may request any practitioner in the applicable department to serve
as his attending physician. Where no such request is made, or when the
requested physician declines, the Medical Staff member who is on emergency
call in the particular department or service will be assigned to the patient. Each
division service line shall provide a schedule for such assignments. Should there
be a dispute in regards to the care of a patient, outpatient, emergent or
inpatient, the Chief-of-Staff has the final authority to determine who shall be
responsible for the patient.
8. Each member of the Medical Staff must assure timely, adequate professional care for his inpatients and outpatients who are utilizing services or facilities of CaroMont Health by being available or having available through his office an eligible alternate practitioner with whom prior arrangements have been made. If call arrangements are made for coverage outside one's specialty area, this must be approved in advance by the medical director of their division or their respective service line medical administrator. Failure of an attending practitioner to meet these requirements shall result in loss of clinical privileges. A practitioner who will be unavailable for over twelve hours must indicate the name of the practitioner who will be assuming responsibility for the care of his patients during his absence. Such notice shall be given to the Medical Staff Office, Emergency Medicine Department and the main Switchboard of the hospital.

9. The duty of care by a practitioner to a patient, once initiated, shall continue until it is ended by consent of the parties or is revoked by dismissal of the patient by the physician, or until the latter’s services are no longer needed or he withdraws from the case. If the practitioner desires to withdraw from the case for any reason, he must give the patient or his representative sufficient notice, in writing, so the patient can procure other medical attention if he desires. The practitioner shall continue in attendance until the conditions of his right to withdraw are complied with. Abandonment of a patient by a practitioner shall result in disciplinary action being taken against the practitioner. Anytime a practitioner withdraws from a case or is dismissed by a patient from a case and the patient needs continuing medical attention, such practitioner shall immediately write a transfer summary for the benefit of the practitioner who will be assuming responsibility for the continuing medical care of the patient.

10. Admissions to critical care units must meet established criteria.

11. Patient transfers:
   Transfer priority shall be as follows:
   a. Inpatients requiring critical care beds.
   b. Emergency Room to appropriate patient bed.
   c. Critical Care to next level of care.
   d. From temporary placement in an appropriate geographic or clinical service area (i.e., PACU, SEOU) to the appropriate area for that patient.

12. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay in accordance with the Utilization Review Plan as approved by the Medical Staff and the Board of Directors. The documentation must contain:
a. An adequate written record of the reason for admission and continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
b. The estimated period of time the patient will need to remain in the hospital.
c. Plans for post-hospital care.

Upon request of the Utilization Review Department the attending practitioner must provide written justification of the necessity for continuing hospitalization of any patient hospitalized for a period defined as "extended duration" in the Utilization Review Plan, including an estimate of the number of additional days of stay and reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for action.

13. Upon admission to the Hospital or upon determination thereafter, patients who meet high risk screens shall automatically be referred to the Care Management Division. There is an open referral system to all disciplines by any healthcare team member.

14. Discharge planning begins at admission. Whenever practicable, notice of the discharge should be given at least twenty-four hours in advance to allow staff adequate time to arrange for any discharge needs (i.e., transportation, home health, indigent medications) to facilitate the patient leaving the Hospital with the goal.

15. A patient may be discharged from the Hospital only on written order of the attending member of the Medical Staff, or of an allied health staff member for whom such member is responsible if so delegated and authorized by such attending member of the Medical Staff. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. If a patient leaves against advice, efforts shall be made to obtain the patient's or his representative's signature on a statement acknowledging the situation and releasing the Hospital and treating practitioner(s) from responsibility.

16. In the event the patient has expired, it shall be the responsibility of the attending physician to pronounce him dead or arrange for such pronouncement by another physician within a reasonable length of time. When a physician is unable to pronounce an expired patient, the Nursing Shift Manager, Director, or clinical support staff may be utilized. However, a physician must pronounce a patient if:
   a. The death is an unexpected outcome;
   b. The patient has been designated as a full Code Blue status;
c. The patient is on a ventilator;
d. The patient is a coroner’s case; or
e. There is the potential for family concerns or controversy that would need physician explanation or intervention.

The body shall not be removed or released until an entry has been made in the medical record of the deceased by the healthcare provider doing the pronouncement. If it is confirmed or suspected coroner's case, the coroner must be contacted.

17. An attending physician or his/her designee shall have examined a patient within 12 hours of admission or sooner according to the clinical status of the patient and place an admission note on the chart within 24 hours with the exception of newborns in The Birthplace or patients on Psychiatric Unit.