CONFIRMED BY

Public institution Grigiskes health care centre director 2018 January 2nd. Order

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**EXTRACTION OF PUBLIC INSTITUTION GRIGISKES HEALTH CARE CENTRE RULES OF PROCEDURE**

 **9.** **PATIENT'S REACHING OUT TO INSTITUTION PROCEDURE**

9.1 Patients‘ reaching out to the institution is regulated by the quality management system‘s procedures:

9.1.1. “Patients‘ reaching out to health care centre ‘s outpatient clinic procedure”, P 04-2003;

9.1.2. “ Patients’ hospitalisation to palliative care hospital procedure”, P 07-2003.

9.2 Patient reaches out to outpatient clinic via phone for:

9.2.1 common information acquisition;

9.2.2 doctor’s consultation via phone;

9.2.3 registration in advance;

9.2.4 doctor’s call to home;

9.3 Patient, who arrived at the outpatient clinic, asking for:

9.3.1 common information acquisition;

9.3.2 registration in advance;

9.3.3 doctor’s consultation the same day;

9.3.4 necessary medical care;

9.3.5 remote health care services;

9.3.6 palliative care services;

9.3.7 other personal health care services.

9.4 Patient must have an identity confirming document.

9.5 Patients are welcome to the outpatient clinic on weekdays from 7:00 am to 8:00 pm., and from 8:00 am to 12:00 pm on Saturdays. Patients seeking family practitioner’s services after outpatient clinic working hours, on holidays and other days off, need to contact the health care institution with which a contract is made for providing these services (information is provided at the institution’s notice board).

9.6 Doctors accept patients at the time provided in the registration slip.

9.7 Patients, unable to arrive at reception on time must inform the registry as soon as possible. A visit can be cancelled by calling registry no.: 243 2103 or by arriving at the centre.

9.8 By cancelling the visit to a doctor, the patient can arrange another visit.

9.9 In the case of a person’s health care specialist coming down with an illness and without any possibility of providing services, in advance registered patients are informed via phone about a postponed visit to a health care specialist. In this case, the date and time of the visit are arranged with the patient. The nurse or any other appointed worker is responsible for informing about visit cancellation and postponement.

9.10 If when accepting a patient without them waiting in the queue, without an in advance registration, other patients are questioning it, the nurse working with the health care specialist must inform them about the reason for accepting the patient without them waiting in line and further patient acceptance order.

9.11 The nurse working with the doctor is responsible for the regulation of patient service procedures at the time of patient acceptance.

9.12 Before the acceptance of the patients the nurse working with the doctor brings patients’ personal medical histories to the doctor’s office. The medical histories of patients who haven’t registered in advance will be brought by the registry worker before accepting the patient. If needed, a patient's medical history and/or other medical documents (analysis’ results, x-ray pictures, etc) can be taken from one doctor’s office to another only by the centre’s workers.

9.13 After the doctor’s working hours, the nurse working with them makes sure to return the medical histories of the patients to the registry. The patient’s personal medical history cannot be returned only if the doctor has informed the registry and provided the return date of the documents.

9.14 In case of an emergency, patients who need urgent help are accepted first (without waiting in the queue)

9.15 Remote health care services (further- RHC service) by using informational and electronic communication technologies, with which there is a way to identify the person, are provided by the family doctor’s team member by the competence established by law when the patient does not have to come to the primary outpatient health care institution.

9.15.1 RHC services are provided by the LR health care ministry’s 2018-07-19 order No. V-826.

9.16 Purpose of the RHC services- providing patients with re-examinations, continuing medical product or medical care equipment prescription (children can only get a prescription for not longer than 1 month)

9.17 RHC service can only be provided if the patient consents (form KVSF 04-24) The agreement must be signed by the patient or patient’s representative. The agreement will be included in the outpatient medical history of the patient.

9.18 Patient who wants to be provided with an RHC service must call the registry. The patient is then listed in a line of patients who wish to get an RHC service.

9.19 Family practitioner’s team member will contact the patient via phone the same or the next day, identify the patient with the procedure referred in the agreement form and provides the RHC service. The patient’s identification is matching the patient’s provided data via phone to the one provided in the agreement.

9.20 In the outpatient medical history of the patient will be noted the date of the RHC service provision, the used communication tool (phone), the reason for addressing, the subjective state of the patient and provided service.

9.21 If it is a new case of treatment, it is forbidden to assess the state of health of the patient remotely, without a live inspection, if the patient is asking for a new prescription of medicine that they have not used before, the RHC service must not be provided. In this case, the patient must register for a consultation in the usual manner.

9.22 After the RHC service is provided, next time if addressed for the same reason, the patient must come to the institution.

9.23 Doctor’s call to home procedure is regulated by the director’s 2008-10-31 order No. 01-05-29. The doctor visits the patients at home at free from patient acceptance at the centre time.

9.24 A minor patient who is under 16 years, health care is provided only with his representative’s agreement, except in the cases of emergency medical care, when in the doctor’s reasonable opinion, noted in the medical documents, the patient can properly assess their state of health, has the right to independently reach out for and decide on the provision of needed health care services, except the cases established by law.

9.25 Palliative treatment and care hospital provides inpatient primary level services for the patients with chronic diseases or disabled patients, by the minister for health of the Republic of Lithuania 2012 May 4th. order No. V-393 “Palliative treatment and care service provision requirement description”.

9.26 Patient, their representative or doctor clarifies hospitalization to palliative treatment and care hospital with deputy director for palliative treatment and care.

9.27 Patients must have a properly filled referral from a family or other physician f No.027 / a.

9.28 If there are no vacancies in the hospital at that time, the patient will be registered for delayed hospitalization.

9.29 The patient must arrive at the hospital at the appointed time. Patients are accepted from Monday to Friday from 8.00 am. until 2 p.m.

**10.** **NOMENCLATURE OF UNPAID SERVICES, THEIR PROCEDURE OF PROVISION.**

10.1 The outpatient clinic provides primary health care services, the scope of which is regulated by the Lithuanian medical norms MN 14: 2019 “Family doctor. Rights, Duties, Competencies and Responsibilities” and secondary health care services.

10.2 Primary outpatient services are provided to those patients who have opted for our centre and are covered by compulsory health insurance. Secondary outpatient services are provided free of charge, for the provision of which an agreement has been signed with the Vilnius Territorial Health Insurance Fund and the centre has not used the funds provided for in this agreement.

10.3 The outpatient services are provided by:

10.3.1 Family practitioners;

10.3.2 Paediatricians;

10.3.3 Internal medicine physicians;

10.3.4 Obstetrician-gynaecologist;

10.3.5 Surgeon;

10.3.6 Odontologist;

10.3.7 Secondary health care specialists;

10.3.8 Nursing staff.

10.4 The hospital provides free inpatient supportive treatment and nursing services, the volumes of which are regulated by the Minister of Health of the Republic of Lithuania in 2012. May 4 Order No. V-393 “Description of requirements for the provision of supportive treatment and nursing services”.

10.5 Inpatient services are provided free of charge to patients who:

10.5.1 are insured with compulsory health insurance;

10.5.2 meets the criteria for hospitalization in this type of hospital;

10.5.3 receive treatment in a hospital for palliative treatment and care for a maximum of 120 days per calendar year;

10.5.4 whose treatment costs are covered by Vilnius city municipality;

10.6 Inpatient services are provided by:

10.6.1 Internal medicine physicians;

10.6.2 Neurologist;

10.6.3 Nurse responsible for general care;

10.6.4 physiotherapist’s assistant;

10.6.5 masseuse;

10.6.6 Physical medicine and rehabilitation nurse.

10.7 Necessary medical care is provided free of charge to all patients.

10.8 The nomenclature of free services is published on the centre's notice boards.

10.9 The order of the provision of paid services is regulated by the quality management procedure P 11-2003 “The order of the provision of paid services”. The number of paid services with prices is posted on the institution's notice boards.

**11.** **PROCEDURE FOR PROVISION OF PAID SERVICES**

11.1 The order of the provision of paid services is regulated by the quality management procedure P 11-2003 “The order of the provision of paid services”.

11.2 The nomenclature of paid services with prices is published on the notice boards of the centre.

**12.** **PATIENT’S RIGHTS**

12.1 The right to quality health care.

12.2 The right to choose a healthcare institution and a healthcare specialist.

12.3 The right to information (about the patient's state of health, diagnosis, other treatments, and examinations used or known to the doctor, possible risks, complications, side effects, the prognosis of treatment, provided health care services, their prices and access to them). If the patient considers that the healthcare professional providing the patient has not been adequately informed and has not answered all questions regarding the provided healthcare, the patient may submit a written claim to the administration of the institution within three working days.

12.4 The right not to know (about your health condition, diagnosis, treatment and examination methods, complications, treatment prognosis).

12.5 The right to access the records in their medical records.

12.6 The right to privacy.

12.7 The right to anonymous healthcare.

12.8 The right to damage compensation

12.9 The right to complain.

**13.** **PATIENT'S DUTIES**

13.1 The patient must get acquainted with the internal rules of the healthcare institution, and other documents established by the healthcare institution and perform the specified duties.

13.2 The patient must take care of their health, exercise their rights fairly, do not abuse them, and cooperate with the specialists and employees of the health care institution.

13.3 In order to receive healthcare, patients must provide proof of their identity, except in the case of emergency care.

13.4 The patient should, to the extent possible, provide healthcare professionals with information about their health, illnesses, surgeries performed, used medications, allergic reactions, genetic inheritance, and other data known to the patient necessary for the proper provision of health care services.

13.5 In the cases prescribed by this Law, a patient who has received information about the health care services provided to them shall confirm their consent or refusal to the provision of these health care services in writing.

13.6 Patients must comply with the appointments and the recommendations prescribed by the health care professionals in accordance with the procedure established by this law. The patient must inform the healthcare specialists of any deviation from the appointments or regimen for which the patient has given consent.

13.7 The patient must treat all healthcare professionals and other patients with respect.

13.8 The provision of health care may be suspended for a patient who violates their duties, endangers their own or others’ health or obstructs others’ access to quality health care unless this would endanger the patient's life.

**14.** **OTHER RIGHTS AND DUTIES OF HOSPITAL PATIENTS**

14.1 Communicate with other people (including other patients), use a personal phone, receive letters or other mail.

14.2 Meet with visitors, their representative without outsiders.

14.3 To buy and receive the necessary items, food that meets the sanitary standards

14.4 Perform religious rites.

14.5 According to the act, hand over personal documents, money and valuables to the senior nurse.

14.6 To manage credentials, wills, summon a priest.

14.7 Follow the hospital's internal rules and daily routine.

14.8 Follow the appointments and instructions of the attending physician and nurse.

14.9 Maintain cleanliness in all hospital facilities. Patients who are self-sufficient must keep their own bed and locker tidy.

14.10 Do not use other beds, bedding, or pillows, do not walk around the hospital in underwear, lie in bed only after undressing and taking off the shoes.

14.11 Do not use personal electric heaters, repair ward lights, electrical outlets and other electrical appliances.

14.12 It is forbidden to store food on cabinets and windowsills. Store perishable foods in polyethylene bags or glass / plastic containers in the patients’ refrigerator.

14.13 Dispose of gauze, cotton wool, toilet paper and other paper, food and other waste in the rubbish bin only.

14.14 Walk only in the hospital area where the hospital administration has designated patients for walking. It is forbidden to self-willingly leave the hospital’s area.

14.15 It is forbidden to smoke, store and consume alcoholic beverages, narcotic substances, make too much noise, and use audio-visual equipment (if wards or other patients oppose).

14.16 Handle hospital equipment and inventory with care. When leaving the hospital, the patient must return the used hospital property to the ward nurses.

14.17 A patient who has damaged property and has made a loss must compensate for the damage caused.

**15.** **OTHER DUTIES OF OUTPATIENT PATIENTS**

15.1 Arrive at the doctor at a given time. If a patient is unable to arrive on time, they should inform the receptionist or treating doctor as soon as possible.

15.2 A personal health history is a centre’s document kept at reception or archive. Neither the patient nor their representatives have the right to keep (store), carry or take this document away from the centre. When a patient enrols in another primary health care facility, their personal health history is sent to that facility upon their written request (Form 025-025-3 / a).

15.3 Do not damage the inventory and other material values of the institution.

15.4 Pay on time and in full for the services provided.

**16.** **PROCEDURE FOR REMOVING PATIENTS FROM A HOSPITAL TO HOME OR REFERRING THEM TO ANOTHER HEALTHCARE INSTITUTION**

16.1 A patient shall be discharged from a palliative care and nursing hospital when the patient's state of health is improving, and inpatient health care is not required.

16.2 In case of a patient's state of health worsening, when specialized medical care is needed, a consultant shall be called, or the patient shall be referred to another health care institution that may provide the necessary assistance.

16.3 If the patient's further presence in palliative care and the nursing hospital is not medically justified, the patient shall be fully informed of the justification for such a decision and the continuity of further health care before discharge from the hospital or transfer to another health care facility. Upon receiving such information, the patient confirms it with a signature.

**17.** **PROCEDURE FOR PROVIDING INFORMATION TO THE PATIENT AND ITS RELATIVES**

17.1 The procedure for providing information to the patient and other natural and juridical persons is regulated by the quality management procedure P 16-2011 “Procedure for providing information to the patient and other natural and juridical persons”.

17.2 All information about the patient's presence in the healthcare facility, treatment, medical condition, diagnosis, prognosis and treatment, as well as all other personal information about the patient is considered confidential even after the patient's death. The right to information after the death of the patient heirs by will and by law, spouse (partner), parents, and children.

17.3 Confidential information may only be disclosed to other persons with the written consent of the patient. The patient has the right to identify persons to whom confidential information cannot be provided.

17.4 In accordance with the procedure established by legal acts, the confidential information may be provided to state institutions to which the laws of the Republic of Lithuania grant the right to receive confidential information about the patient against their will.

17.5 Injured patients who may have been harmed by a crime must be reported immediately to law enforcement.

**18. PROCEDURE FOR MAKING COPIES, DUPLICATES AND ISSUING MEDICAL DOCUMENTS**

18.1 Upon presenting the identity confirming documents, the institution shall, at the request of the patient, make and issue copies of the patient's medical documents certified by the institution, as well as issue descriptions of the diagnosis and treatment.

18.2 Copies or transcripts of medical documents may be issued to other natural or juridical persons only in accordance with the procedure established by the laws of the Republic of Lithuania and only upon their written request, stating the basis for the request for information, the purposes of its use and the required information.

18.3 Copies of documents required for patient referral for consultation, treatment to other institutions and disability and working capacity assessment office shall be made at the expense of the Centre.

**19.** **PROCEDURE FOR RESOLUTION OF DISPUTES AND CONFLICTS BETWEEN THE INSTITUTION AND PATIENTS**

19.1 The patient has the right to file a complaint to the institution if he considers that his rights have been violated.

19.2 The procedure for submission and examination of complaints of the patient and of persons interested in the personal health care of the patient is regulated by the quality management procedure P 09-2003 “Procedure for the application and examination of complaints of the patient and of persons interested in the personal health care of the patient’’.

19.3 The patient or their representative may file a complaint. Complaints are examined if they are signed by the patient, have the patient’s name and surname provided, the actual place of residence and contact details, and the essence of the complaint is given. If the complaint is filed by the patient's representative, the name of the representative, his place of residence, the document certifying the representation and the patient on whose behalf he is applying shall be indicated. Unreadable complaints that do not meet the requirements of this section shall be returned to the patient and the reason for the return shall be stated.

19.4 The patient must provide proof of identity in the complaint. When such a complaint is sent by post or courier, it must be accompanied by a copy of the applicant's identity document certified by a notary or the patient's lawyer. When requesting such information, the patient's representative shall provide proof of identity and representation.

19.5 The patient has the right to file a complaint no later than one year after becoming aware that their rights have been violated, but no later than three years from the date of the violation.

19.6 Upon receipt of a patient's complaint, the institution must examine it and inform the patient in writing of the results of the examination within 20 working days.

**20.** **PROCEDURE FOR REGISTRATION AND STORAGE OF PATIENT’S ARTICLES OF PRECIOUS METALS, PRECIOUS PROSTHESES AND MONEY:**

20.1 When a patient is admitted to a palliative treatment and care hospital, if the patient so wishes, their articles of precious metal, expensive prostheses and money may be stored in the hospital:

20.1.1 a list of the patient's values is made in two copies;

20.1.2 on the bottom of each copy by the hospital's senior nurse and patient have to sign;

20.1.3 one copy of the list is given to the patient, the other with the values indicated in the list is placed in an envelope;

20.1.4 the envelope is sealed and placed in the safe in the hospital's senior nurse's office;

20.1.5 at the patient's request, the envelope is opened, the values are checked according to the list and the patient signs that all values have been received;

20.1.6 A list of values signed by the patient is pasted into their medical history.

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