APPROVED
Director
April 30, 2014 Order No K4-220

INTERNAL RULES OF PROCEDURE

I. GENERAL PROVISIONS

Public Institution Panevezys Hospital Internal Rules of procedure regulate the relationship between staff and patients in the diagnosis and treatment, patient counseling or rehabilitation, both, in outpatient and inpatient settings.

The purpose of Internal Rules is to provide legally safe medical care to patients, to inform patients about their rights, and to remind them of their responsibilities.

These internal rules of procedure are a public document published in information stands, on the hospital's website, in binders, in inpatient units, in the Consultation Polyclinic.

Patients familiar with Internal Rules of Procedure confirm this with a signature on the Hospital director – approved Information form (Patient Consent to Information and written confirmation of study and treatment).

The patient shall be introduced to the Internal Rules of Procedure in the inpatient unit, or when the patient first arrives at the Consultation Polyclinic. Staff in departments are introduced during the production meetings.

II. PATIENTS REFER TO THE TREATMENT INSTITUTION PROCEDURE

1. Consultation Polyclinic. Patients are registered for scheduled consultation with specialists.

Reception is open for consultation on weekdays I-V from 7:20 a.m. till 20:00 p.m. Registration phone numbers:

- for children - (8 45) 507 109
- for adults - (8 45) 507 262; (8 45) 507 124
- for oncologist chemotherapists - (8 45) 507 150
- for dermatologists and infectologists - (8 45) 587 531
- on the website www.panavezioligonine.lt or www.sergu.lt.

- Re-consultation or evaluation of research- registration is done by a specialist consultant or under his direction of a nurse working together, the date which fits for both parties.

For registration You must specify your full name and personal ID number, inform whether you have a referral from a general practitioner (GP), and indicate yours prefer specialist.

The front desk staff registers with a specialist (preferred specialist) by suggesting the nearest, or the patient's requested consultation date, issuing a visit voucher stating the doctor's name, date, time and office.

When registering by phone or online, the patient is recorded on the day sheet of the appointment, marking the reception time and other data provided by the patient.

Patients have the right and the opportunity to contact a senior nurse in case of uncertainty during the registration process by telephone (8 45) 507 136 or by contacting “in face” in offices number 105 and 107.

Note:

In Consultation Polyclinic, medical staff must provide urgent medical assistance during the patient's acute illness. Emergency Institutional Medical Assistance continued / provided at Hospital Admission - Emergency Department.

2. Registration for inpatient treatment.

2.1. **Providing emergency medical care** in the Hospital Admission - Emergency Department, registration is done after doctors have performed a patient examination. The Reception-Emergency department records all referrals.

- outpatient patients - in computer media, noting the time of referral, patient name, surname in the outpatient record book.

- for inpatient treatment in the accounting book for inpatient patients.

2.2. **For scheduled hospitalization,** patients will be registered by specialists' consultants in reception of Consultation Policlinic. For Surgical profile – in Day Surgery unit reception by telephone No: (8 45) 502 111. With General practicioner physician's sending's, in accordance with the harmonised stationary quota, specifying time for hospitalisation. Data on planned hospitalization scans are transmitted through the Statistical office to the reception desk. When with the arrival of other inpatient, the transportation of patients by reanimobiles, pre-registration is carried out through the Hospital's orgmethodical office.

Scheduled or planned hospitalization from the Primary Health Care Center is recorded according to a pre - agreed plan.

Day Surgery Unit Tel. no. (8 45) 502112; 507 196; local tel. no. 2 666; 2 270; 2 776.

III. PATIENT ACCEPTANCE FOR CONSULTATION IN CONSULTATION POLYCLINIC

3. Patients for examination - for consultation or scheduled examination are admitted with a referral from a doctor, at the time indicated in the admission certificate and / or registration form, after checking the patient's insurance.

For patients who are covered by compulsory insurance: research, counseling and treatment at the Consultation Polyclinic (CP) are covered by PSDF insurance funds, and patients do not pay for this service. The study and treatment plan is made by the consultant and informed to the patient.

Insured persons with additional self-insurance shall be provided free of charge only under the conditions and to the extent specified by the insurer.

In the absence of compulsory or voluntary health insurance, the patient is offered paid medical care at the rates set by the Ministry of Health of The Republic of Lithuania, in accordance with procedures approved by the Hospital Director.

Note: The prices and procedure for paid services are indicated on the information stand and on the patient's request at the reception desk. Paid services are offered at the patient's request for additional medical services.

After the consultation, study and treatment results, recommendations for further treatment are written in form 027/a and forwarded to the General practicioner physician, or the specialist who sent it, with entries on form 025/a.

IV. HOSPITALISATION OF PATIENTS AND EMERGENCY – PROVIDING ESSENTIAL ASSISTANCE IN THE RECEPTION - EMERGENCY DEPARTMENT/ UNIT

4. In The Emergency Department, all patients who have suffered trauma or worsened somatic and mental illness are recorded for medical examinations.

The first and institutional (qualified) medical assistance is provided free of charge. The procedure and mindset of necessary medical assistance is regulated by Order No V-208 ministry of Health of the Republic of Lithuania 2004-04-08. Necessary aid shall be granted in the event of:

Category 1 - is a life-threatening condition requiring immediate medical intervention.

Category 2 - when the patient is in severe condition or deteriorating rapidly and if there is risk of organ failure without medical assistance;

- when extreme emergency treatment with antidotes, thrombolysis is required;
- when there is an extremely severe case of pain.

Category 3 - where there is a potential threat to life if no medical assistance is provided in half an hour.

Category 4 - is a potentially threatening condition for a patient with a deteriorating condition and can lead serious consequences if no medical assistance is provided in 1 hour.

Reception - Emergency Department/Unit physician or consultant is called to assess the patient's condition after examination, and records on the examination sheet according to the categories of necessary assistance.

This medical assistance is provided by the internal disease doctor, surgeon, traumatologist - orthopedist from "Trauma Center", and, if necessary, other specialists and other surgery general practice nurses in Emergency Unit.

The physician records the start of emergency care and its service in medical records/ documents at the Reception – Emergency Department/ Unit.

Reception – Emergency Department/ Unit physician, after examination and prescribed examinations or short-term monitoring decide whether the patient is hospitalised or after outpatient care is discharged to the supervision of a General Practitioner.

According to the type and scope of medical assistance provided, data of examination and treatment study is written in form 025/a TLK, in statement 027/a, and if hospitalised - in the form 003/a.

Patients need to know:

In the case of the necessary medical assistance, interventions we require your or your parents/guardians, written informed consent, confirmed by a signature, in a form provided by medical staff, for admission to intervention and/or to provide information about your hospital stay, treatment.

In the event of refusal of treatment, the patient shall, in the same order, approve the refusal by signature, when the medical staff informs of possible negative consequences without finishing treatment or monitoring of the condition.

5. **Hospitalisation in Psychiatric Department/ Unit -** conditions for hospitalisation and registration shall be the same for those described above.

When the patient's state of health poses a threat to himself or those around him, and without the patient's consent, the patient may be compulsorily inpatient for up to 2 days by decision of a physician psychiatrist. The continuation of forced treatment must be a court order.

6. Maternal/ maternity inpatient:

Examination of pregnant woman performed in the reception room of the obstetrics/ midwifery corps tel. no. (8 45) 507 291 (obstetric reception). Pregnant woman is examined by a midwife, or in a more difficult situation by obstetric gynecologist. Hospitalizing the data of the examinations, and studies are recorded in form No.096/L (birth history).

7. **In hospitalization in The Infectious Diseases Clinic,** patient examination is carried out in the reception ward of Infectious diseases clinics and/or in the Reception Department/Unit of Public Institution Panevezys Hospital.

7.1. **Cases of quarantine disease:** patients who are suspected of infectious disease are examinated in the isolated room "box" of the Reception - Emergency Department and/or in the reception ward of infectious diseases clinics, by direct contact. After an inspection in the isolated room "box" of the Admission- Emergency Department, patients are transported by emergency department (on call) to the Infectious Diseases Clinic,

During **an Epidemic or Pandemic Period,** at the order of the director, infected patients are taken in the reception room of the infectious corps, or simply in the pre-boxing rooms of wards.

Infectious corps Reception Room tel. no. (8 45) 586 753.

In Reception - Emergency department, emergency medical care is provided by specialists 24 hours a day. In the case of indications and the decision of the doctor, laboratory, instrumental, radiological and endoscopic examinations are carried out, when it is necessary to assess the patient's condition or to determine the diagnosis of the disease.

Note: The patient's Reception – Emergency department physicians inspect, investigate and determine the availability of the service according to the objective state of the patient's health, not according to the registration queue.

V. PLANNED HOSPITALISATION OF PATIENTS

8. Sheduled patients' hospitalization shall be carried out in a separate post of reception unit "sheduled patient reception". Patients who needs staying/ laying in the hospital shall take place at the following time:

Surgical profile

Patient flow profile	Registration start time (hours)
General surgery	7^{00}
Traumatology	7^{00}
Vascular Surgery	8^{00}
ENT: ears, nose and throat	8^{00}
Eye Diseases	8^{30}
Orthopedic	9^{00}
Urology	9^{30}
Neurosurgery	12^{00}

Therapy profile

Patient flow profile	Registration start time (hours)
Oncology – chemotherapy	9^{30}
Cardiology	10^{00}.
Internal diseases	10^{30}
Gastroenterology	10^{30}
Neuroscience	11^{00}
Endocrinology	11^{30}
Nephrology	11^{00}
Psychosomatic – psychiatry	12^{00}
Rehabilitation	13^{00}

Other units/ chapters

Patient flow profile	Registration start time (hours)
Children's Diseases	9^{00} - 13^{00}
Gynecology	7^{30}
Daily Surgery	7^{30}
Obstetric pathologies	9^{00}
Infectious diseases clinic	7^{30}

Note: Patients must be provided with a personal ID document at the reception, during hospitalization.

We offer hospitalized patients to bring essential personal hygiene measures.

In urgent cases, patients are hospitalized 24 hours a day, and documents are delivered later to the appropriate unit.

VI. PATIENTS BEING IN THE HOSPITAL RULES

9. Patients must maintain order and cleanliness in the hospital premises and wards, as well as care of the bed, clothes, and individual lockers. Food is allowed in refrigerators.

10. When leaving the ward, patients must take care of their belongings or transfer them to the ward nurse in temporary care.

11. Patients in the wards must keep an agenda:

7 am. getting up;
7 am.-7:45am temperature measurement, toilet;
8 am. procedures, research (for children);
8:30 am breakfast (for children);
8 am. - 9 pm. breakfast;
9 - 10 pm. morning visitation;
10 am - 1 pm. procedures, investigations, consultations, visits by department heads. Patients should be in the ward during the visit;
1 pm. to 2 pm. lunch;
2 pm. to 4 pm. afternoon rest (patients must be in their wards or beds);
4 pm. – 6 pm. procedures, medical research, tests;
6 pm. to 7 pm. dinner;
7 pm. – 8 pm. evening visitation;
8:30 pm. – 10 pm. leisure time, walking;
10 pm. (11pm. in summer) time to sleep. Patients should be in bed, the TV turned off, the light turned off.

12. Patients must not disturb other patients' peace of mind: make noises, use radios in a way that does not interfere others.

13. Patients are strictly forbidden to use intoxicants (cigarettes, drugs, alcohol etc.) in the hospital and its territory. The patient shall be discharged immediately from the hospital for this violation of procedure and shall be noted in his medical records.

VII. PATIENT VISITATION RULES

14. Patients can be visited **daily 11 am -1pm. and 4 pm.-7 pm.** Up to 2 visitors at a time and should not exceed 30 minutes. Visitors leave the ward during physician visits and make procedures. Visitors may be called out for breaking the rules of attendance.

15. Administration may restrict or terminate patient visits.

16. For family members of patient, if there is need of ongoing care, head of department may issue individual access pass.

17. Visiting patients with children is not recommended. Access to some sections may be restricted or prohibited. Visitors must leave the ward immediately, at the request of the doctor/physician or nurse.

18. Walking in coats, jackets, raincoats, etc. is not allowed in the hospital.

19. Recommended to consult a physician or nurse for advice on bringing patients food.

VIII. PROCEDURES FOR PRESCRIBING AND TRANSFERRING PATIENTS TO OTHER HEALTHCARE ESTABLISHMENTS

20. If the patient's continued stay in that hospital is not medically justified, the patient is discharged from the hospital to the home or sent to another health care facility. Before being discharged from a health care facility to a home or sent to another health care facility, the patient's doctor explains in detail the validity of such a decision. After receiving such information, the patient confirms with the signature in his history of the disease. For providing information to the patient is responsible patient's doctor and/or head of the unit.

20.1. Patients are discharged from the hospital in violation of the procedures established in the hospital, arbitrarily leaving the hospital, at the request of the patient, marking the fact of the violation of internal procedures in the diary.

20.2. Scheduled prescribing of patient takes place till 12:00 a.m. on weekdays. Patient is being informed about that no later than a day ago.

20.3. Patient under the age of 16 are discharged in the presence of parents or their representatives, and only when patient can be picked up by their parents or representatives.

20.4. For further treatment, patients are transported from the departments to other personal health care facilities in accordance with the procedure established by the Director of hospital with hospital transport. **From Reception - Emergency Department/Unit, the patient is transported to the home or the receiving institution by the GMP service (ambulance) after providing the necessary assistance but without stationary care.**

IX. PATIENT RIGHTS

21. The right to receive qualified healthcare.

21.1. Patients' rights may not be restricted on grounds of sex, age, race, nationality, language, origin, social status, religion, beliefs, opinions, sexual orientation, genetic characteristics, disability or any other unlawful circumstance.

21.2. Every patient has the right to be respected for his or her honor and dignity non-degrading conditions of the health care personnel being in care of hospital and in case of death. Any intervention in the patient's body and health, including research and tests, must be carried out in accordance with appropriate professional obligations and standards.

21.3. Patients should be provided with science- based analgesics to avoid suffering from their own health disorder.

21.4. The patient's body or its body parts must not be used for commercial gain. Any part of a patient's body can only be removed for patient's health care purposes. For other purposes, the removed part of the body may be stored and used only in accordance with the procedure laid down by law and only if the patient's consent has been obtained, the patient was informed of the consequences of such consent.

22. Right to access health care.

The State establishes that the citizens of the Republic of Lithuania and other state citizens permanently residing in Lithuania have the right to receive state-guaranteed (free) personal health care. Essential medical care is provided free of charge to all residents of Lithuania, regardless of whether they are covered by compulsory health insurance.

Scheduled health care services are provided for insured persons with compulsory health insurance. Referral by a family physician/ doctor is required for scheduled personal health services.

Compulsory health insurance funds cover:

- primary, secondary and tertiary health care costs;
- costs of prosthetics: limbs, joints, organs and cost of prostheses;
- the cost of reimbursing medication and medical supplies;
- government support for the purchase of orthopedic appliances;

- costs of preventive medical care;
- medical rehabilitation (outpatient and inpatient) treatment costs;
- insured persons of European Union Member States, Iceland, Liechtenstein, Norway and Switzerland, who have submitted European Health Insurance Cards issued by the competent institutions, are entitled to medical treatment in the institutions of Lithuanian National Health System covered by the Compulsory Health Insurance Fund funds.

Insured persons of the Member States of the European Union, Iceland, Liechtenstein, Norway and Switzerland are also entitled to receive payments from the Compulsory Health Insurance Fund at the health care institutions of Lithuania under E 112 form certificate (or its replacement S2). Also has the right to receive planned health care provided by the budget of the Compulsory Health Insurance Fund in the treatment institutions of the National Health System of Lithuania.

Paid personal health care is provided in the following cases:

- The service is included in the list of paid personal health care services approved by Ministry of Health of The Republic of Lithuania, 1999-07-30 Order No. V-357 "On the list of paid personal health care services, the procedure for determining prices and indexing them and the procedures for the provision and payment of these services" (order No V-794 of 11.7.2014).
- The patient is not covered by compulsory health insurance and the service provided is not classified as necessary assistance, as described in Order No. V-208 of Ministry of Health of The Republic of Lithuania 2004-04-08 "On the approval of the necessary procedure and scope of medical assistance services".
- The patient is not a permanent resident of Lithuania.
- The patient did not have “the sending” of a doctor working for the Lithuanian National Health System. In cases where the patient is insured with compulsory health insurance and the specialist doctor determines that the patient has applied reasonably, the costs of further treatment are paid from the PSDF budget (Primary Health insurance fund).
- At the patient's request, with the permission of the attending physician, additional services are provided which are not related to the treatment of the underlying disease.
- The patient wishes to receive the service out of order and the institution has the possibility to provide more services than provided for in the contract with the territorial sickness fund.
- Paid personal health care is provided by ensuring that all patients registered in their queue receive these services, paid for by the PSDF budget (Primary Health insurance fund).

22.1. Healthcare should be available to the patient. The conditions for the implementation of this right are established by the laws and other legal acts of the Republic of Lithuania.

22.2. **Safe personal health service:** in the hospital patients are registered, admitted, treated in accordance with the prescribed procedure. Patients receive medical assistance in acute cases of illness and trauma, as well as elective outpatient, inpatient counselling. Work in departments and offices is organized in prepared workplaces, which have sanitary passports. Workplaces, equipment and facilities comply with Hygiene standards (HN 47:2011 "General personal health care facilities, health safety needs"). The work of staff is organized in compliance with the requirements of the "Law on Workers and Health": staff periodically check their health. Staff are employed for statutory working hours, provided rest periods.

22.2.1. Adequate working conditions for safe interventions, operations, patient monitoring and care are provided in the hospital. Supervision of complex radiological equipment is carried out by a specialist in medical supervision of the equipment. Regular epidemiological surveillance is carried out by the Infection Control Unit, which is carried out by HN 47-1:2012 "Health care institution infection control requirements".

22.3. The necessary medical assistance to the patient must be provided, in accordance with the orders of the Minister of Health of the Republic of Lithuania, in a matter of urgency. In the case of persons who are in need of medical assistance, first aid, medical care, as a result of accident, accidents, ecological and natural disasters or acute illness, or patients at the places of accident or life-threatening acute illness, all the professionals of helth care, pharmatics also are required to provide

such first aid assistance. If the patient's stay in the health care facility can not provide adequate emergency medical care in a timely manner, or if the health care institution is unable to provide the necessary medical care within the limits of its competence, it must inform the patient and ensure that the patient is transported to another healthcare facility as soon as possible.

23. The right to choose a physician/ doctor, a nurse practitioner and a health care facility.

The patient has the right to choose a doctor, a nursing professional and a health care institution. This right may be restricted only on the grounds specified in the laws of the Republic of Lithuania and in accordance with the procedure established by legal acts.

24. The right to receive information.

24.1. The patient has the right to be informed about the services available in healthcare institutions and how to access them.

24.2. The patient must be introduced with the name, position and qualifications of the attending physician and nurse.

24.3. The patient must be introduced of patients' rights and obligations, with Internal Rules of the health care institution. The patient is entitled to a description of diagnosis, treatment and care.

24.4. The patient has the right to get information about his or her medical condition, diagnosis of the disease, tests performed, their results, treatment methods and treatment prognosis. When providing information about treatment, the physician should explain to the patient the progress of treatment, possible outcomes of treatment, possible alternative treatment methods and other circumstances that may influence the patient's decision to accept or refuse the proposed treatment, as well as the consequences of refusing the proposed treatment. Information should be provided to the patient according to his age and state of health, in a form that he understands, explaining special medical terms.

24.5. The healthcare institution may not report the information provided for in point 24.4 to the patient, including minors between the ages of 16 and 18, only if the notification was a clear precondition for serious harm to the patient (health or endanger his life). In such cases, all the information provided for in this point shall be provided to the patient's representative and shall be treated as an informative submission to the patient. The information provided to the representative shall be provided to the patient, as soon, as the risk of the patient being notified did not causes damage anymore. The information is not reported to the patient if he refuses information.

24.6. At the request of the patient, a medical history, an outpatient card or other medical records of the patient must be provided, unless this may substantially harm the patient's health or endanger his life. In such cases, the attending physician notes about the restrictions on the provision of information in the history of the disease. The rights of a mentally ill person to access the patient's medical records are determined by the Mental Health Care Act.

25. Patient involvement in teaching and biomedical research.

25.1. Without the patient's written consent, he or she cannot be included in biomedical research. Consent may only be sought after the patient has been informed of the purpose, nature, effects and risks of the specified process and tests.

25.2. When the consent (permission) referred to in item 25.1 is available, the patient may be involved in biomedical examinations only in accordance with the procedure established by the Law on the Ethics of Biomedical Research and other legal acts.

25.3. The inclusion of a patient in the training process and scientific medical tests (biomedical tests) must be guided by the notion/idea, that the patient's interests and well-being are more important than scientific interests.

26. **The right to choose diagnostic and treatment methodologies and to refuse treatment.**

26.1. Patients may be treated or provided with any other healthcare or care only with their consent.

26.2. Where, in accordance with health care standards, it is possible to choose diagnostic and treatment methodologies, the patient shall be introduced of the features of these methodologies and

shall be given an option of choice. For patients, the choice is formalized in writing. For underage patients under the age of 16, as well as for other patients who, because of their condition, are unable objectively assess diagnostic and treatment methodologies, their representatives are chosen to sign. If there is disagreement between underage patients under the age of 16 and their representatives, diagnostic and treatment methodologies shall be chosen by the doctors' consilium, taking account the interests of the minor.

26.3. Before requesting the consent referred in point 26.2, patient (his representative) shall be informed of the purpose, nature, consequences and risks of intervention to the patient's health. The personal healthcare provider shall record all personal health care services in the patient's medical records. The consent for services for which no healthcare contract has been concluded shall be confirmed by the signature of the patient (his representative) in the patient's medical records.

26.4. The patient may cancel his/her consent to treatment at any time in writing. Where the patient is in a condition which is unable to assert his or her will as a result of consent to treatment and the choice of diagnostic and treatment methodologies, the will he has expressed above in writing shall be taken into account as far as possible without prejudice to the patient's interests. In the absence of the will of the patient (his representative) expressed in accordance with the procedure, care, diagnosis and treatment may be applied only on the grounds of law, and procedure established by law, where there is a real threat to the health or life of the patient or persons around him. The provision of first or urgent medical care to a patient who, because of his age or state of health, is unable properly express his or her will, The Hospital needs the consent of the patient's or representative. The patient is involved as much as possible when the issue of consent for treatment is in decision. Assistance may be provided without the consent of the representative if it is not available, or the consent cannot be obtained in due time, or the representative refuses to give his consent and the provision of medical assistance is in the patient's best interests. This is noted in the history of the patient's disease.

26.5. If the representative of a patient who, because of his age or state of health, refuses to give his consent to treatment which is not urgent, and the provision of medical assistance is in the patient's best interests, such treatment may be given if the doctors/ physicians have the consilium and made a consent, or the Medical Ethics Committee of the Health Care Institution, or the Lithuanian Committee on Bioethics mane a consent/ agreement. At the request of the treating physician, the administration of the health care institution forms the consilium of doctors. The Medical Ethics Commission or the Lithuanian Bioethics Committee may be contacted by the administration or treating physician of the health care institution. The characteristics of the treatment of a patient, a mentally ill person who is unable correctly assess their state of health, are determined by the Mental Health Care Act. In all cases, the patient is, as much as possible, involved in giving consent to treatment.

27. Right not to know.

27.1. Information about state of health, diagnosis of the disease, medical examination data, methods of treatment and prognosis of treatment must not be provided to the patient against his will. The will of the patient, including minors between the ages of 16 and 18, must be clearly stated in the healthcare contract or confirmed by the patient's signature on the patient's medical records.

27.2. The provisions of point 27.1 shall not apply, where failure to provide information to the patient or other persons may lead to harmful consequences and cannot be avoided by providing information to the patient's family members, his representative or other persons. About providing information to the patient against his will, the doctor notes in the patient's medical records. The characteristics of treating a patient who is unable correctly assess his or her state of health as a result of mental illness, are determined by the Mental Health Care Act.

28. Inviolability of private life.

28.1. Patients private life is inviolable. Information about patients' lives may be collected with the patient's consent and only if it is necessary for the diagnosis, treatment or nursing of the disease.

28.2. 28.2. In health care institutions, information on the patient's presence in the health care institution, his or her state of health, diagnostic, therapeutic and nursing measures applied to him or

her shall be entered in the forms and medical records prescribed by the Ministry of Health. The form, content, and procedure for using these documents must ensure the protection of the patient's privacy.

28.3. All information about a patient's hospital stay, treatment, medical condition, diagnosis, prognosis and treatment, as well as any other personal information about a patient, must be kept confidential even after the patient's death. The procedure for the storage of such confidential information is established by the laws of the Republic of Lithuania, legal acts approved by the Minister of Health of The Republic of Lithuania. **Confidential information may only be provided to other persons with the written consent of the patient.** In those cases, when persons are directly involved in the treatment or care of a patient, confidential information may be provided and given, without the patient's consent, when it is necessary to protect the patient's interests. In addition to the patient's consent, 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 his will, in accordance with the procedure established by legal acts. Where the patient has lost consciousness and there is no his consent for confidential information, confidential information may be provided to the patient's representative, spouse/partner, parents (adoptive parents) or adult children, only in cases, to the extent necessary to protect the patient's interests.

28.4. The use of information for scientific and educational purposes shall not prejudice the patient's personal privacy. The procedure for the use of information contained in the medical documents of patients for scientific purposes shall be established by the Law on the Ethics of Biomedical Research, and the procedure of the use of this information for training purposes is established by the Government or an institution authorized by it.

28.5. In order to ensure the patient's right to privacy, the provision that the interests and well-being of the patient is more important than the public interest. The unlawful collection and use of confidential patient information is under responsibility in accordance with the procedure established by legal acts. Without material damage, the patient is also compensated for non-material damage.

29. Right to appeal/ complain.

29.1. Considering that his rights as a patient are violated, the patient (his representative) shall contact the head of the healthcare institution in writing. The head of the healthcare institution or the person in office of the health care institution must, within a possible short period of time, but within a maximum of 20 working days, investigate the case under appeal and inform the patient (his representative) in writing of the outcome of the examination.

29.2. Dissatisfied with the examination and its results, the patient (his representative) may apply to the court or to the public institution which controls the hospital.

30. Right of compensation.

30.1. The patient shall be entitled to compensation for damage caused by violation of his rights in the provision of healthcare. The conditions and procedure for compensation of damage, the conditions and procedure of compensation for patients are established by Chapter III of the Law on amending the Law on the Rights of Patients and Health Damage, as well as the Civil Code, the Law on Insurance, and other legal acts.

30.2. The patient shall submit an application for possible damages in writing.

X. PATIENT DUTIES

31. The patient must become familiar with Internal Rules and other documents established by health care institution and must fulfill the duties specified therein.

32. The patient must take care of his or her health, use his or her rights fairly, do not abuse them. Cooperate with health care professionals and staff.

33. Patients must provide identification documents, except for essential health care, in order to receive healthcare.

34. Patient should provide as much information as possible about their health, medical conditions, surgeries, medications used and consumed, allergic reactions, genetic heredity, and other data known to the patient that are required to provide health care properly.

35. A patient who has received information about the health care services provided to him shall confirm consent or refusal to provide such health care services in writing.

36. The patient must follow the appointments and recommendations of the health care professionals or can refuse in writing. The patient must inform health care professionals of deviations from the appointments or established regimes for which he has given his consent.

37. Patient must treat all healthcare staff and other patients with respect and dignity.

38. A patient who is in breach of his or her duties, endangering his or her health and life or other patients, or interfering their access to quality healthcare, healthcare may be suspended unless this would put the patient's life at risk.

XI. DISPUTES AND CONFLICTS BETWEEN HOSPITAL AND PATIENTS DECISION PROCEDURE

39. In the event of a dispute, conflict between hospital and patients, contact the head of department where the conflict occurs.

40. If the conflict is not resolved, contact the hospital administration orally and/ or in writing.

41. If the conflict is not resolved at the hospital, contact the founder of the hospital - the Ministry of Health of The Republic of Lithuania (Vilniaus g. 33, Vilnius).

42. Both parties may apply to the court to resolve the conflict.

XII. INFORMATION TO THE PATIENT AND HIS/ HER RELATIVES REPORTING PROCEDURE

43. All information about the patient's condition, diagnosis, treatment, care may be provided to other persons only with the written consent of the patient (his / her representative). No information is available on the phone.

44. The patient (his / her representative) should be acquainted with the Internal Rules by signature.

45. The physician/ doctor introduces the treatment plan to the patient and his representative, notes that the patient (representative) has read and agrees to the treatment plan. The patient (his / her representative) confirms this with his / her signature in the patient's medical history / personal health history.

46. If the patient (his / her representative) refuses the prescribed examination and treatment, the physician shall record this in the inpatient medical history / personal health record. The patient confirms with his or her signature in the inpatient medical history / personal health record, which the physician presents to the patient for signature.

47. The treating physician shall inform the patient (his / her representative) of any changes to the examination and treatment plan. In the medical history, the physician notes that the patient (his / her representative) has been informed and agrees with the changes to the study and treatment plan.

48. The patient's written consent is required for surgery / diagnostic procedures. It is the responsibility of the physician who prescribes the surgery or the diagnostic procedure to submit the patient for signature and affix patient's consent to the medical history.

49. The physician informs the patient about the established diagnoosis of the desease, the result of research and treatment, and the conclusion of the consultations.

50. When prescribing a patient from a hospital, the physician/ doctor informs the patient about recommendations for health care.

51. All information about the patient may be provided for official purposes without the written consent of the patient or his representative, where the information must be provided, in accordance the procedure laid down by law:

51.1. for healthcare facilities where the patient is being treated, cared for or undergoing medical examination;

51.2. for institutions which are controlling healthcare;

51.3. to the Court, the Prosecutor's Office, to the institutions of pre-trial investigation, to the municipal services for the protection of the rights of the child, and other institutions to which the Law of the Republic of Lithuania grants such a right.

52. The information is followed 2001-02-01 by Order No.65 of the Minister of Health of the Republic of Lithuania on "The approval of the procedure for providing information about the patient to public authorities and other institutions", 2001-04-18 No. 270 on amendment of the procedure for "Providing information on the patient to public authorities and other institutions", Order No V-155 of 6.3.2003 on Order No. 65 of the Minister of Health of the Republic of Lithuania of 1 February 2001 on the state authorities and other bodies'.

53. Phone numbers for information:

Outpatient Consultation Clinic tel. no. (8 45) 50 71 36 (local no. 2710)
Inpatient tel. no. (8 45) 50 71 86 (Local no. 2286)
In Infectious Case tel. no. (8 45) 58 75 51 (Local no. 8224)

Working hours of Administration, Economy units:
I-IV 8 am. to 5 pm.
V 8am. to 3:45 pm.
Lunch break 12 am.-12:45 pm.

Visits with Hospital director call tel. no. (8 45) 50 72 44

On holidays, the hospital's senior surgeon is on-call, authorised by the Director to perform the necessary administrative actions/ steps.

T**he surgeon is called via Orgmethodical room tel .no. (8 45) 50 72 92 local. No. 293**

XIII. PROCEDURES FOR ISSUING DUBLICATES/ COPYS TO A PATIENT OR OTHER JURIDICAL PERSON SICKNESS HISTORIES, OUTPATIENT CARDS, OTHER DOCUMENTS

54. Originals, copies, copies (extracts) of medical histories and other medical documents; certificates of hospital treatment may be given to: court; public prosecutor's office; pre-trial investigation bodies; municipal child rights protection services, institutions controlling healthcare services; healthcare facilities where the patient is being treated, cared for or undergoing a patient's health examination. Documents shall be issued to these authorities upon written request, entrustment or other document, signed by the head/director of that institution, which must be submitted in such cases, in accordance with the law governing the work those institutions, with the permission of Hospital Director or the Director Deputy of Medicine.

55. Patients or their representatives wishing to receive:

55.1. Copies of extracts from medical documents (epicrises) about their previous hospitalization shall be contacted by the hospital Document management department /unit. Copies of extracts from medical documents (epicrises) shall be issued only with an identity document. Patients pays for copying services at the Cash office;

55.2. After the end of treatment, within 3 days of the patient being discharged from the hospital, an extract from the medical documents (epicrisis) is sent to the family doctor (general practitioner or internal disease doctor). Daily epicrisis of inpatient patients are given on the same day.

XIV. PROTECTION OF PATIENTS' CLOTHING AND PERSONAL BELONGINGS IN HOSPITAL UNITS

56. When patients lie in hospital, we recommend that money and other material values, clothing add for storage in accordance with the procedure, specified by the Director:

- money and material values are accepted for storage by senior departments nurses. When material valuables and money are added for storage, acceptance forms shall be made in duplicate and signed by the senior nurse and the patient. Valuables are reserved until the patient is discharged or upon written request to return the valuables.
- Clothing for storage added from the Reception Department to the clothing warehouses.

57. Senior nurses are guided by the doctor's order K4-81 of 19.3.2010.

58. Patients' clothes may be handed over to escorts during hospitalisation or accepted for storage in the dressing room by filling in the dressing sheet- form 1/SAM.

The Administration is not responsible for the quality of storage soiled or torn clothes.

Patients' clothing after accidents or criminal events shall be stored until the deadline specified by law.

Clothes are stored for up to 1 month after discharge.

Information for relatives of the patient after death (Appendix 1).

Republican Hospital of Panevėžys
The Internal Rules of Procedure
Annex 1

INFORMATION FOR RELATIVES
PATIENT'S DEATH

In the case of the patient's death, his family members or his representatives, indicated by contact telephones are informed. If the deceased's identity is not identified, we inform police in writing.

In the event of the death of a patient in a Unit/ Department where the diagnosis is not in doubt and there is no request for an autopsy by relatives, is issued a form 106/a "Medical death certificate" in the unit. Relatives contact treating physician. When applying, you need to have a deceased patients' ID and your ID (identity document).

In the case of the death of the patient, an autopsy is performed in accordance with the procedure established by the laws of the Republic of Lithuania, without prejudice to relatives or legal representatives. In the case of a violent death, an autopsy is issued by law enforcement authorities. The consent or disagreement with the autopsy is confirmed by relatives in a form approved by Ministry of Health of The Republic of Lithuania, after hearing the information of the administrative representative.

The hospital shall guarantee free protection of the deceased's body until it is withdrawn by the members of the deceased's family, his representatives or persons indicated by the patient before his death, but for a maximum of 4 days.

The body of the deceased is issued to relatives from the Department of Pathology:
weekdays from 8:00 am. to 4:30 pm.
Saturday: 8:00 am. to 2:00 pm.
contact phone no. 8 45 507 252; 507 216.

The deceased's body is issued from the Forensic Medical Experts Office after autopsies from 8:00 am. to 3:00 pm., information is available by tel. no. 8 45 463 171.

When the deceased's body is issued, relatives get clothing and personal belongings also.

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