CHRISTUS TRINITY MOTHER FRANCES Health System

CHRISTUS MOTHER FRANCES HOSPITAL RULES AND REGULATIONS

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RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall accept patients for care and treatment.

2. A patient may only be admitted to the Hospital as an Inpatient or placed in Observation by a member of the Active or Courtesy Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.

3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion 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 staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

   a. Physicians utilizing APCs must see their non-ICU patients within twenty-four (24) hours of admission or consultation. ICU admission and consults must be seen within twelve (12) hours by the attending physician. This does not negate the need for the APC to see the patient within a timely manner. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.

4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

5. 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 Admitting Department to ascertain whether there is an available bed.

6. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that such said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

7. A patient who is admitted on an emergency basis may select any consenting practitioner in the applicable department or service/section to attend to him. Where no such selection is made, the member of the Active or Courtesy Staff on call in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairman of each department and/or service/section shall provide a schedule for such assignments.

8. Trinity CHRISTUS Mother Frances Admissions will admit patients on the basis of the following orders of priorities and placement determined by Bed Control:

a. Emergency Admissions

Within 24 hours following an emergency admission, the attending practitioner shall document the need for this admission on patient's medical records. History and Physical shall suffice. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

b. Pre-Operative Admissions

This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Department Chief of Surgery may decide the urgency of any specific admission.

c. Routine Admissions

Shall be accepted from an Active or Courtesy Category Medical Staff member. Reservations shall be accepted in Bed Control and must be received by facsimile (fax), telephone, or hand-delivered information. Orders for admission shall be received in Bed Control prior to admission or at the time of the patient's arrival**.**

d. Day Surgery patients must be admitted at least two (2) hours prior to their surgical procedure.

9. Areas of restricted bed utilization and assignment of patients shall be in accordance with approved recommendations of the Hospital Practice Improvement Committee and specified in Hospital policy. It is understood that when deviations are made from assigned areas as indicated above, Bed Control will correct these assignments at the earliest possible moment, in keeping with transfer priorities.

10. Patient Transfers. Transfer priorities shall be as follows in the following priority:

a. Emergency Care Center to appropriate patient bed;

b. From Obstetrical patient care area to general care area, when medically indicated;

c. From Critical Care Department to general care area;

d. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible practitioner.

11. The admitting practitioner shall be expected to give such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

12. For the protection of patients, the Medical and Nursing staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

    a. Patients admitted for suicidal intent or overdose to the Intensive Care Unit area must have their suicidal status evaluated at time of transfer from the unit.

        (1) If patient remains suicidal or has suicidal inclinations, the patient should be transferred to an appropriate facility. The patient may be transferred to a CHRISTUS Mother Frances Hospital Nursing Unit if a qualified Hospital staff member is in constant attendance.

        (2) If the patient is not suicidal or does not demonstrate suicidal inclinations, the patient may be transferred to an appropriate facility or routine nursing unit.

13. Admissions to Intensive Care Unit

    The criteria for admission to the Intensive Care Unit shall be based on the severity of illness and intensity of service and the likelihood of benefit from receiving ICU level care. Severity of illness relates to the patient's abnormal physiology whereas the intensity of service relates to the use of monitoring, the degree of critical care technology being applied, the medications being used and to the intensity of bedside nursing care that must be administered.

    Patients admitted to the ICU by a cardiologist must consult an intensivist if the patient's ICU stay exceeds forty-eight (48) hours. Patient orders must be available at time of admission. Physicians must provide patient orders by telephone or facsimile.

    If any question as to the validity of admission to or discharge from the Critical Care Department should arise, that decision is to be made through consultation with the Medical Director of the ICU. A specialist must be consulted in all complicated situations where the specific skills of other practitioners may be needed. All urgent or stat consults are to be Physician to Physician requests. Stat or urgent consults shall be documented in the progress notes.

    The Attending Physician or consulting physician responsible for the care of the patient in the ICU response times for Critical Care admissions and transfers are as follows:

    Unstable Patients – Response time is within 60 minutes of admission or transfer to the ICU. Examples of unstable patient: shock of any etiology that has not responded to initial therapy or ventilated patients that are difficult to oxygenate or ventilate.

    Stable Patients – Response time is within six (6) hours of admission or transfer to the ICU.

    Attending physicians may delegate initial ICU assessment to an Advanced Practice Clinician (APC). Advanced Practice Clinician (APC) are responsible for

reviewing the case with the Attending Physician immediately following their initial assessment. and documenting time and date in the medical record.

If the patient remains unstable or becomes unstable after being initially evaluated by the Advanced Practice Clinician (APC), then it is the responsibility of the Attending Physician to do a bedside assessment within 60 minutes of initial admission or transfer to the ICU or obtain consultation with an intensivist.

14. Patient/Discharge

Patients shall be discharged only on a written order of a member of the Active Medical Staff. or their APC after appropriate collaboration has occurred and is documented in the medical record.

a. 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.

15. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. Suicides, known or suspected and accidental deaths, shall be reported to the local law enforcement authorities. Policies with respect to release of dead bodies shall conform to local law.

16. It shall be the duty of all staff members to secure autopsies whenever possible in keeping with Policy D.76. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies performed in the Hospital shall be performed by a Pathologist on the Medical Staff. Provisional anatomic diagnoses shall be recorded on the medical record within a reasonable time. The complete autopsy report should be made a part of the record within 30 days.

17. The use of restraints shall be limited to only those situations in which alternatives have failed or there is imminent danger to self or others. Any use of restraints requires appropriate clinical justification. A written time limited order is necessary from the physician for each use of restraints. PRN orders shall not be accepted. (Refer to Policy D-117 approved by the Medical Staff).

B. MEDICAL RECORDS DOCUMENTATION

1. **Attending Physician Responsible**. The attending practitioner is the physician of record and is responsible, within the scope of his/her license and privileges, for the professional quality care and treatment of each patient s/he admits and cares for, holds legal and ethical responsibility for directing care of the patient and ensures the patient's documented visit accurately reflects the care rendered, clinical outcomes and treatment plans.

2. **History and Physical Exams**. A complete history and physical (H&P) exam has the following components: history, physical examination, assessment and treatment plan as indicated:

a. History and Physical Exams. A complete H&P has the following components: history, physical examination, assessment and treatment plan as indicated:

i. History includes:

- Presenting diagnosis/condition (chief complaint/reason for the visit)
- Description of symptoms
- Current medications, biological, nutraceuticals will no longer be required in the H&P, but can be found in the EMR under Medication Reconciliation.
- Any drug allergies
- Significant past medical & surgical history
- Review of systems
- Psychosocial status
- Nutritional evaluation (if GI, pediatrics, or elderly)

For surgery or invasive procedure requiring moderate sedation or anesthesia:

- Indications
- Proposed procedures
- ASA Classification: regardless of whether Anesthesiology is providing care
- Immunizations (pediatric patients only)
- Neonatal history (pediatric patients, if applicable)

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

- Vital Signs
- Cardiovascular system
- Respiratory system
- Neurological system
- Gastrointestinal system
- Eye
- Ear, nose and throat (ENT)
- Genitourinary system
- Musculoskeletal
- Skin
- Psychiatric
- Hematologic/lymphatic/immunologic

c. Assessment

d. Treatment Plan

3. **<u>Interval H&P</u>**. The interval H&P must reference the previously performed complete H&P and must contain documentation of the changes in medical history or physical exam, or a statement indicating that no changes have occurred. The interval H&P must provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status since the original complete H&P.

4. **Focused H&P**. The focused H&P is a brief account of the patient's condition and must provide sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status. It should include:

- History of present illness (including chief complaint)
- Current medications, biological, nutraceuticals
- Relevant past medical and surgical history
- Family history
- Relevant review of systems
- Indications and proposed procedures for any surgery or invasive procedure
- Physical examination as indicated
- Assessment
- Treatment Plan

NOTE: Focused H&P is referenced in the use of Sedation and Anesthesia.

5. **Daily Care of Patients/ Progress Note**. A hospitalized patient must be seen by the Attending Physician or a member of the house staff, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient on the day of visit in sufficient detail to allow formulation of a reasonable picture of the patient's clinical stats at the time of observation.

6. **Operative Care of Patients.** Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care. The surgeon may start dictation immediately after operative or other high risk procedure, which may be prior to "closing" by an assistant.

The brief operative or procedure note must include the following elements:

- The name of the primary surgeon and assistants
- Postoperative diagnosis
- Procedure performed
- Estimated blood loss or indicate "note", if there was no blood loss
- Complications or indicate "note", if there were no complications.

A full operative or procedure report must be documented or dictated for transcription within 24 hours after surgery. The report should contain:

- Preop diagnosis
- Postop diagnosis
- Operations performed
- Principal surgeon, assistant surgeons, type of anesthesia administered
- Intraoperative findings
- Description of the procedures performed
- Intraoperative complications, if any

- Specimens removed
- Estimated blood loss
- Type of anesthesia or sedation
- Date and time of procedure

7. **Discharge Summary**. The primary purpose of the patient record is for documenting the care of the patient. All patients are required to have a Hospital Discharge Summary (HDS) completed which is accurately crafted to recapitulate the reasons for the hospitalization, describes the significant findings including complications, pertinent events of the patient's hospitalization, procedures performed and treatment rendered; the principal and secondary diagnoses, condition of the patient on discharge; and any specific instructions and orders for follow-up care.

The Hospital Discharge Summary is a "Power Document" which provides comprehensive and succinct information regarding a patient's hospital course in a uniform format. The Hospital Discharge Summary is the primary *communication tool*, between the hospital care team, referring physician and all post-hospital providers; the primary document for *transitioning care,* to enable a subsequent physician or practitioner to reference and understand the patient's medical history; and an important tool to prevent readmissions, improve continuity care and comply with meaningful use and core measure requirements. The HDS is also the primary *reference document* for coding all clinical services and documentation of quality improvement activities and is a signed *legal document* to be used for legal purposes, patient care, referrals, performance and quality metrics.

The Joint Commission mandates six components to be included in the Hospital Discharge Summary. (Standard IM.6.10, EP7)

- Reason for Hospitalization – chief complaint and/or history of present illness.
- Significant findings – Final and primary diagnoses.
- Procedures and Treatment provided – Hospital course and/or hospital consults and/or procedures.
- Patient's discharge condition – Documented sense of the patients' condition at discharge.
- Patient and family instructions - discharge medications, activity orders and/or therapy orders, dietary instructions and plans for medical follow-up.
- Attending physician's signature - signature of the Attending Physician, date and time on the discharge summary.

Documentation Standardization

Required Components of the Hospital Discharge Summary. The format and content should be consistent with the rest of the medical record to include:

- Patient name and demographics
- Admitting and Discharge dates
- Providers
    - Attending, Consultants, Referring and Primary Care Physicians
- Reason for Hospitalization
    - Primary / Final Diagnosis

    - Secondary diagnoses
    - Co-morbidities recorded in diagnostic terms
    - ICD-10 Mindset
- Procedures performed
    - Listing of all procedures performed with results, treatment rendered and complications (if any).
- Update Problem List
    - Formal utilization to identify "New and Chronic" pertinent Problems
    - Update resolved Problems
- Hospital Course – Succinct description
    - Brief pertinent history warranting hospitalization
    - Diagnostic plan developed based on symptoms and working diagnosis
    - Treatment / Interventional plan with significant findings and results
    - Consulting services
    - Pending results and follow up care
- Final physical exam, vital signs and DC weight
- Patient Status – Condition of patient, response to care and prognosis
- Discharge Disposition
    - Accurate Medication List
    - Follow-up plan
    - Specific instructions given to patient and/or family
    - Diet and activity recommendations
    - Rehabilitation potential and plan
- Post-Hospital Plan
- Secure follow-up appointments and referrals prior to discharge.
- Reporting
    - Copies of HDS forwarded to Attending, Referring, Consultants and Primary Physician

The Attending Physician (e.g. the physician who is the designated *"attending"* during the current hospital stay is responsible) is responsible for:

(i) Completing the Hospital Discharge Summary; or
(ii) Arranging for another physician or APC to complete the Hospital Discharge Summary

Any delinquency in the timely completion of the discharge summary is the responsibility of the Attending Physician.

Entries at conclusion of hospitalization. All diagnoses, co-morbidities, complications, and procedures must be recorded in full at the time of discharge, without the use of symbols or abbreviations, and must be dated and signed by the Attending Physician. The Attending Physician has the responsibility for the accuracy of this information.

The following definitions are applicable to the terms used herein:

- *Principal Diagnosis:* The condition established as the principal or final diagnosis, to be chiefly responsible for causing the admission of the patient to the Hospital for care.
- *Secondary Diagnosis* (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending provider(s) considers significant factor affecting patient's condition and response to therapy.
- *Comorbidities*: A complicating condition that coexisted at admission with a specific principal diagnosis developed and/or worsened through the hospitalization and is thought to increase the length of stay.
- *Complications* (if applicable): An additional diagnosis that describes a condition arising after the beginning of Hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay.
- *Principal Procedure* (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
- *Additional Procedures* (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

Approval Process. All custom Hospital Discharge Summary Templates developed by different specialties and service lines must have the required components designated in these Bylaws for this document. All Hospital Discharge Summary templates require prior approval from the Med Exec Committee.

A discharge clinical summary shall be completed on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Executive Committee of the Medical Staff, and for these, a final summation-type progress note shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner and shall include instructions for post-hospital care. Discharge summary is the responsibility of the Attending Physician.

8. **Death Summary** - The Death Summary is entered in the electronic health record or dictated for transcription and the content of the death summary should be consistent with the rest of the record and include:

    - Admitting date and reason for hospitalization
    - Date of Death
    - Final Diagnoses
    - Succinct summary of significant findings, treatment provided and patient outcome
    - Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
    - Documentation of all procedures performed during current hospitalization and complications (if any)

9. **Copy Forward.** Clinical information should never be "cut and pasted" from different patient charts. When specific elements of the same patient's prior notes do not change from one encounter to the next during the same clinical episode, those elements may be copied forward or preferably acknowledged by reference rather than re-entered. Examples of information that is less controversially copied or carried forward by reference – when truly needed to communicate decision-making for the active encounter – include elements of the previously recorded:
   - Past Medical/Surgical/Obstetric/Psychiatric History
   - Family History
   - Social History
   - Past relevant reports (labs, imaging, pathology, etc.) with dates
   - Some unique circumstances where other aspects of the patient's history might be copied, such as when the patient is unable to provide this information and the original source (typically a family member or guardian) is no longer accessible.

   A patient note must always reflect the status of the patient at the time of note creation. It is inappropriate to Copy Forward elements of the History of Present Illness, Physical Examination, and Assessment and Plan without modifying these elements to reflect current status of the information, including specific notation of Assessment and Plan that pertains to the current condition of the patient.

   In addition, the History of Present Illness, Physical Examination, and Assessment and Plan should reflect the work product of the final author and **not** be carried forward from other providers' notes except in the unique circumstances noted above, and then only with attribution to the original author.

10. **Problem List Utilization.** The problem list should be continuously updated to reflect the medical conditions being treated in the acute care hospital stay, to the greatest degree of specificity possible. It is the responsibility of each provider seeing the patient to address the problem list, but the overall responsibility resides with the Attending Physician. Consultants should add medical problems being addressed by their consultation.

11. **Informed Consent**. It shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical, surgical and anesthesia procedures requiring informed consent. This entry must also be dated and timed. This may be documented in the Physician Progress Notes, in the Operative Report or on the Physician Pre-Sedation Assessment History & Physical or by signing the Anesthesia, Surgical & Medical Informed Consent signed by the patient.

12. **Do Not Resuscitate**. It is the responsibility of the physician writing a "Do Not Resuscitate" order to document in the Progress Notes that the patient or patient's surrogate was involved in the decision.

13. **Consults**. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the

consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations, be verified on the record, and be recorded prior to the operation. Consultations are to be completed within twenty-four (24) hours of the time of request, except as set forth in the applicable ICU or NICU admission policy of the Medical Staff.

14. **Prenatal Record Requirement**. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

15. **Legibility, Date, Time, Authentication**. All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated in either written or electronic form by the author.

16. **No Unapproved Symbols or Abbreviations**. Designated unapproved symbols and abbreviations should not be used. An official record of unapproved abbreviations should be kept on file in the record room. The use of Unacceptable/Do Not Use Dangerous Abbreviations shall result in clarification with the practitioner in the interest of patient safety. The use of Unacceptable/Do Not Use Abbreviations applies to all orders and all medication-related documents.

17. **Final Diagnosis**. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

18. **Patient Consent for Release of Records**. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

19. **American Joint Cancer Committee Staging Form**. The medical record contains the American Joint Cancer Committee staging form and the managing or treating physician must assign the TNM elements and stage group and sign or initial the staging form.

20. **Record Safekeeping**. Original hard copy records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or state law. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

21. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the IRB and Governing Board. Subject to the discretion of the Administrator or his designee, former members of the medical staff shall be permitted free access to information from the medical records of

their patients covering all periods during which they attended such patients in the Hospital.

22. All medical records shall be maintained in accordance with the Record Retention and Destruction Policy of the respective facility.

23. A practitioner's preprinted order, when applicable to a given patient, shall be reproduced in detail in the patient's record, dated and signed by the practitioner prior to institution of the order unless delay in physician authorization may cause harm to the patient.

24. All orders (except verbal orders as set forth below) must be dated, timed and authenticated by the next time the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the Medical Staff and granted privileges which are consistent with the written orders, provides care to the patient, assesses the patient, or documents information in the patient's medical record.

25. All verbal orders must be dated, timed and authenticated within forty-eight (48) hours by the prescriber or another practitioner who is responsible for the care of the patient.

26. Medical records shall be completed within fourteen (14) calendar days following discharge.

    a. In order to manage the record completion process, The Health Information Management Department will send a notification letter once monthly advising practitioners of the need to complete all delinquent records within 14 days of receipt of the notification.

    b. Failure to complete records within the designated time frame will result in temporary suspension of admitting and/or clinical privileges until such time as all delinquent records are completed.

    c. Suspension letter informs the physician in writing that the attached summary medical records report must be completed by a specific date and time; and if the medical records remain incomplete that his/her admitting and/or clinical privileges shall be denied until all delinquent medical records have been completed. This is inclusive of physician signatures / electronic signatures on transcription.

    d. Suspension letters for failure to complete medical records will be included in the provider's credentialing file and tracked in the OPPE database.

    e. Physicians may access the electronic medical record system to obtain detailed information regarding their incomplete and delinquent medical records at any time.

    f. When a private patient of the suspended physician desires admission to this Hospital, the patient shall name another physician of his choice or otherwise be admitted to the applicable Department of the physician on

emergency call.

g. Three such suspensions of admitting and clinical privileges within any 12-month period may be sufficient cause for referral to the Medical Executive Committee for action.

h. Medical Executive Committee may take such action as necessary up to and including recommendation of termination, additional CMEs, and other appropriate actions against any physician with three suspensions within any 12-month period.

C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has been refused by the patient. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is admitted to the Hospital.

2. The Medical Staff shall recognize the rights of patients to self-determination including:

   a. The right to accept or refuse medical or surgical treatment;

   b. The right to formulate advance directives such as through the appointment of an agent to make decisions on his/her behalf (Medical Power of Attorney) or the physician written instructions about health care (Directive to Physicians which includes the Out-of-Hospital DNR).

3. In situations wherein the physician and family or patient disagree on resuscitative measures, the physician, utilizing sound medical judgment, will counsel with the family and patient, document the conversation thoroughly in the medical record and will then respect the patient and/or family's wishes for that care. (See Patient Self-Determination Policy, A – 24)

   a. If an Attending Physician disagrees with and refuses to honor a treatment decision chosen by a patient or the patient's representative, the conflict shall be reviewed by the Ethics Committee. The patient shall be given life-sustaining treatment at a minimum through the review process. The Attending Physician shall not be a member of that committee.

   b. If the physician, patient or the patient's representative responsible for the healthcare decisions of the patient is requesting life-sustaining treatment that the Ethics Committee decides is inappropriate, the patient shall be given life-sustaining treatment pending transfer. The physician and the facility will work together to transfer the patient to a willing provider.

   c. If within ten (10) days a willing provider cannot be found life-sustaining treatment may be stopped unless a court of law has granted an extension of time within which life-sustaining treatment must be given. (See Ethics Committee Policy, A-23).

4. All orders for treatment shall be in writing or electronically submitted and must comply with current Hospital policy for telephone orders.

5. The practitioner's orders must be written clearly, legibly and completely and dated and timed. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.

6. All previous orders are reconciled when patients go to surgery or the ICU.

7. All drugs and medications administered shall be those approved by the Food and Drug Administration. Drugs for approved clinical investigations may be exceptions. Investigational drug protocols will be approved by the Investigational Review Board (IRB). These shall be conducted in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Food and Drug Administration.

8. Any medication which the patient brings with him for continued use in the Hospital should be duly recorded by the physician, or nurse and placed in the custody of the charge nurse.

9. Medication shall be administered to patients only by registered nurses or licensed vocational nurses properly oriented and according to Nursing Service policies and procedures; or by physicians; or **Advanced Practice Clinician (APC) with prescriptive authority by the following licensed persons: respiratory therapists; radiology technicians; nuclear medication** technicians; physical therapists; pharmacists, when done so within the scope of their responsibilities and consistent with laws and regulations, and policies of their department. All such administrations of medication shall be pursuant to the order of a prescriber with clinical privileges granted by the Medical Staff. The pharmacist shall dispense medication only for use under such circumstances.

10. Generically equivalent drugs will be administered by the Pharmacy.

11. Any qualified practitioner with clinical privileges in this Hospital may be called for consultation within his area of expertise. If usual methods of obtaining a consult are unsuccessful and the Attending Physician believes patient care will be compromised without appropriate consultation, the Section Chief, Department Chairman, President or President-Elect of the Medical Staff may require a consultation based on the appropriate unassigned Emergency Department call schedule. Such a required consultation will be mandatory and performed in an expeditious manner by the on-call member of the Medical Staff.

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12. Consultation is encouraged in the following situations:

    a. When the patient is not a good risk for operation or treatment;

    c. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

    c. Where there is doubt as to the choice of therapeutic measures to be

utilized;

d. In unusually complicated situations where specific skills of other practitioners may be needed;

e. In instances in which the patient exhibits severe psychiatric symptoms; and

f. When requested by the patient or his family.

13. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.

14. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained she/he shall call this to the attention of his/her supervisor who in turn may refer the matter to the Clinical Director, Clinical Coordinator, Chief Nursing Officer and/or Medical Director. If warranted, the Chief Nursing Officer or her designee may bring the matter to the attention of the chairman of the department and/or section chief wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chairman of the department and/or section may himself request a consultation.

15. All Allied Health Professional personnel who are either in the employ of a private Medical Staff Member or whom he brings in for either teaching or assisting purposes are the direct responsibility of that individual physician. Failure by the Allied Health Practitioner to comply with Bylaws, Regulations, or Hospital policy may result in the suspension of Allied Health Practitioner supervision privileges for the Medical Staff Member. Advanced Practice Clinician (APC) Personnel shall be credentialed according to the medical staff process. Dependent Allied Health Professional Personnel shall be credentialed according to Allied Health Professionals Manual, Section 1.7-7.

16. All clinical laboratory procedures ordered by the physician shall be performed in the Hospital laboratory if such procedures are available. Laboratory procedures not available in the Hospital laboratory may be referred only to laboratories recommended by the Chief of the Pathology Section and approved by the Medical Executive Committee.

17. Diagnostic and therapeutic radiology services shall be maintained and directed by one or more qualified radiologists. Performance and interpretation of radiological examinations shall be made by a qualified radiologist whose name shall be specified in the written order for the examination by the referring physician. Privileges to perform specific limited interpretative diagnostic and monitoring radiologic studies which have been granted to staff physicians who are not radiologists should be of a highly specialized nature, the performance of which requires special qualifications or training and/or experience in the use of the equipment and in the interpretation of results, as well as practice in a field of related diagnostic/therapeutic activities. Credentials files of all physicians thus

engaged shall reflect the training, experience and current competence required for the aspects of radiological services for which they are engaged. All off-site therapeutic radiology shall be referred to an appropriately accredited facility that has been recommended by the Department Chairman and approved by the Governing Board when not available in-house.

18. Laboratory, x-ray and other reports of diagnostic procedures performed outside the Hospital but related to a patient's current admission shall be placed on the patient's record to substantiate the diagnoses and treatment.

19. The legal code of the State of Texas, regulating adoptions and child placements, shall be observed and enforced at all times.

20. In the interest of patient safety critical lab values called to the physician shall be read back so as to confirm accurate transmittal to the physician.

21. Medication reconciliation is a prescribing activity and as such the execution of medication reconciliation is seen as a responsibility of the physician. Medication reconciliation shall be completed on admission, at the time of patient transfer to a different level of care and at the time of the patient's discharge.

22. To facilitate the care of the patient, timely care is required and all patients admitted through the Emergency Department shall be seen by the Attending Physician of record no later than 12:00 Noon on the day following their admission. Orders written by the Emergency Department physician shall expire at the time the patient is seen by the Attending Physician of record, or no later than 12:00 Noon the day following their admission. The Attending Physician shall be notified via telephone at 7:00AM and reminded of the patient's admission and expiration of orders at 12:00 Noon. Patients shall be seen daily by the Attending Physician or consultant who may have assumed care of the patient.

23. All patients admitted to the Hospital or placed in observation will be evaluated by a member of the Active or Courtesy Medical Staff. Allied Health Practitioners may not independently admit patients.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from patients, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. It shall be the physician's obligation to have the required informed consent form completed prior to surgery or any other medical procedure requiring consent.
2. In keeping with the requirements of the Texas Medical and Disclosure Panel it shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical and surgical

procedures requiring informed consent. The date and time informed consent is given must also be documented by the physician pre-procedure.

3. Except in severe emergencies, the preoperative diagnosis and pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. In elective surgery the history and physical must be completed and on the medical record prior to surgery.

4. All patients shall be assessed preoperatively according to Medical Staff approved policies. This assessment shall be documented by the practitioner prior to conducting emergent and non-emergency operative and other procedures.

5. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and physician member of the Medical Staff.
   a. Dentists' or Podiatrists' responsibilities:

      (1) A detailed dental or podiatric history justifying Hospital admission;

      (2) A detailed description of the examination of the oral cavity or podiatric issue and a preoperative diagnosis;

      (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;

      (4) Progress Notes as are pertinent to the oral or podiatric condition;

      (5) Clinical resumé (or summary statement);

      (6) Pertinent instructions to patient and/or family at time of discharge.

   b. Physicians' responsibilities:

      (1) Medical history pertinent to the patient's general health;

      (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

      (3) Supervision of the patient's general health status while hospitalized.

   c. The discharge of the patient shall be on written order of the dental or podiatric member of the medical staff and he will be responsible for post-operative instructions.

   d. Patients admitted to the Hospital for oral maxillofacial/dental surgery and/or podiatric care shall receive the same basic medical appraisal as patients admitted for other services, whether the appraisals are performed by a physician member of the medical staff, Oral and Maxillofacial Surgeon or

other qualified licensed individual in accordance with state law and hospital policy to complete an admission history and physical examination qualified to complete an admission history and physical examination and assess medical risks of the procedure to the patient. A physician member of the medical staff shall be responsible for the care of medical problems that may be present upon admission or that may arise during hospitalization of the Oral Surgery patient.

e. Patients admitted for Podiatric care shall receive the same basic medical appraisal as patients admitted for other services. A qualified practitioner shall be responsible to complete the history and physical exam and assess the medical risks concerning the procedure as it pertains to the patient prior to surgical intervention. The Podiatrist shall be responsible for the portion of the history and physical examination related to Podiatry prior to surgical intervention.

f. When Podiatric surgery is being done under general anesthesia, an Anesthesiologist will be responsible for the anesthesia and for any resuscitative efforts should they be needed.

6. The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, or pre-sedation evaluation immediately prior to induction or moderate deep sedation/analgesia and post-anesthetic or post-sedation/analgesia follow-up of the patient's condition. Post-anesthesia assessment, to be done within forty-either hours of discontinuation of anesthesia and prior to discharge from the Hospital, include: 1) respiratory function including respiratory rate, airway patency, and oxygen saturation, 2) cardiovascular function including heart rate and blood pressure, 3) mental status, 4) temperature, 5) pain, 6) nausea and vomiting, and 7) postoperative hydration.

7. All tissues removed at operation, with the exception of those exempted by the Pathologist and Medical Staff shall be sent to the “selected” Pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

8**.** Surgeons must be in the operating room and ready to commence operation at the time scheduled and in no case will the operating room be held longer than fifteen minutes after the time scheduled.

9. Planning, marking and making a surgical incision or administering a pain block is the responsibility of physicians who have been involved in a formal surgical or anesthesia training and who hold surgical or anesthesia privileges for the specific procedure being performed. Non-physician providers privileged to do so may perform a subsequent incision when directly supervised by the surgeon.

10. All general Dentists and Podiatrists will have a physician Anesthesiologist in attendance for all anesthesia administered in the Hospital and Outpatient Services.

E. GENERAL RULE REGARDING PROHIBITION OF CONTRACEPTIVE

STERILIZATION

Contraceptive sterilization is prohibited. All cases involving a procedure that induces sterility for non-pathologic reasons as an unintended but foreseeable secondary outcome must be referred to the Ethics Committee.

F. EMERGENCY SERVICES

1. Emergency room services, other than those provided by the Emergency Department Physician, shall be provided by the physician on call on a rotation basis. Patients who are admitted to the Hospital on an emergency basis and who do not have an Attending Physician may request any consenting practitioner without obligation in the applicable department or section as determined by the Emergency Department Attending Physician. Where no such selection is made, the member of the Active Category Staff or Courtesy Category Staff, Locum Tenens division on call in the department or section will be assigned to the patient. Physicians on call must be able to physically respond in person to the Emergency Department within thirty (30) minutes. The chairman of each department and/or section or his designee shall provide a schedule for such assignments. Each Medical Staff department/section shall formally define the age members of their specific department/section are eligible to be relieved of their on-call responsibility. When there are insufficient Active Category physicians in a department or section to provide full call coverage, each physician in the department or section shall assume a reasonable response obligation at the discretion of the Medical Executive Committee.

2. An appropriate medical screening within the capability of the emergency department, including ancillary services routinely available to the emergency department, shall be provided to all individuals who come to the emergency department seeking care or if a prudent layperson observer would conclude from the individual's appearance or behavior have a need for examination and treatment of a medical condition. This medical screening examination (MSE) will be conducted by a physician or APC who has received training in emergency medical services and can render immediate life-saving treatment. To the extent possible, the physician on duty shall oversee the MSE.

   The patient presenting with a private physician on the staff shall be the responsibility of that physician and his/her designee will be notified if requested. The medical staff shall provide an appropriate required medical screening examination consistent with the symptom(s) for individuals presenting in the Emergency Care Center to include all necessary ancillary services routinely available to the ECC before discharge or transfer.

3. The duties and responsibilities of all personnel serving patients within the Emergency area shall be defined in policy and procedure. The contents of such policy and procedure shall be developed by the Department of Emergency Medicine.

4. An Advanced Practice Clinician (APC) may not substitute for an Active member of the medical staff in providing call responsibility for the Hospital. If an Advanced Practice Clinician (APC) is assisting in the call responsibility of their

supervising physician, the Emergency Department Physician has the authority to speak directly with the physician on call and request their presence within 30 minutes.

5. Patients admitted or placed in observation to the Hospital under the care of an Attending Physician should be seen on day of admission and must be seen by noon of the following day unless otherwise directed under Intensive Care Unit admissions.

6. Consultation performed in the Emergency Department at the request of a member of the Medical Staff and assisted by an Advanced Practice Clinician (APC) must be seen and evaluated by a Sponsoring Physician prior to discharge home from the Emergency Department

7. The Medical Staff member on-call may not refuse an appropriate transfer of an individual if the Hospital has the specialized capabilities, available personnel and space for appropriately treating the needs of an individual requiring a higher level of care.

8. The Emergency Department Medical Staff or the Medical Staff member on-call shall provide an appropriate medical screening consistent with the symptom(s) when: individuals arrive at the Hospital who may or may not be under the immediate supervision of a personal Attending Physician; has one or more diagnosed or undiagnosed medical conditions; and, within reasonable medical probability, requires immediate or continuing Hospital services and medical care; or requests medical treatment. This screening shall include ancillary services routinely available to the ECC before transfer.

9. Pregnant women of greater than twenty (20) weeks gestation who present with isolated pregnancy-related complaints shall receive a medical screening by a qualified medical provider in the L&D area.

10. A qualified medical provider for the L&D area is a licensed practitioner with current clinical obstetrical privileges or a registered nurse who has been deemed competent through core and/or annual competencies to provide a nursing assessment and diagnosis of the following in the pregnant patient: true vs. false labor; evaluation of FHTs; observation of the regularity and duration of uterine contractions and status of membranes.

11. If a nurse midwife, clinical nurse specialist or registered nurse performs the medical screening, the patient's status must be discussed with the responsible obstetrician prior to the patient being discharged. The responsible obstetrician must decide whether the findings constitute a medical emergency.

12. If the case is beyond the Advanced Practice Clinician's (APC's) expertise or scope of practice, the obstetrician shall examine and evaluate the patient to conduct further medical screening. Following Obstetric evaluation, if a non-pregnancy related emergency medical condition is suspected, the patient may be transferred to the ECC after consultation with the Emergency Department Physician or an appropriate consultant shall be called to evaluate and stabilize the patient.

13. The Medical Staff shall inform each patient or the person acting on his/her behalf of the risks and benefits to the individual of examination and treatment and/or transfer and take all reasonable steps to secure the patients written consent to refuse such examination and treatment and/or transfer.

14. The transferring Medical Staff member shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and sustain the patient during transfer. He shall also determine and order the appropriate medical personnel and equipment for the transfer.

15. Prior to each individual transfer the transferring Medical Staff member authorizes the transfer shall personally examine and evaluate the patient to determine the patient's medical needs and to assure that appropriate transfer procedures are utilized unless the time required would unnecessarily delay the transfer to the detriment of the patient.

16. An appropriate medical record shall be kept for every patient receiving emergency service in accordance with current standards of the Joint Commission. This information shall be incorporated in the patient's Hospital record if patient is admitted to the Hospital.

17. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

18. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be approved by the Medical Staff.

G. RULES REGARDING ALLIED HEALTH PROFESSIONALS

1. Rules regarding Allied Health Professionals are found in the Allied Health Professionals Manual.

2. Unless otherwise provided by Hospital policy or scope of practice, the Sponsoring Medical Staff Member shall:

   (a) Abide by the Bylaws, Rules and Regulations, policies and procedures governing the service of AHPs in this Hospital and utilize the AHP in accordance with the AHP's delineated scope of practice and/or authorized scope of service in the Hospital;

   (b) Be specifically privileged by the Credentials Committee to supervise AHPs;

   (c) Accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of the Bylaws, Rules and Regulations, policies and procedures of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise;

   (d) Maintain ultimate responsibility for directing the course of the patient's medical treatment and provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented;

(e) Ensure that the AHP maintains the necessary qualifications and competency to provide services as required in these Bylaws;

(f) Delegate the performance of any medical acts in accord with applicable law and within the AHP's delineated scope of practice and authorized scope of service; and

(g) Notify immediately the Credentials Committee or Medical Staff services office in the event any of the following occurs:

i. Termination of an agreement to serve as a Sponsoring Medical Staff Member or employment of the AHP;

ii. The Sponsoring Medical Staff Member's approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing board; or

iii. The Sponsoring Medical Staff Member is notified of investigation of the AHP or of the member's supervision of the AHP by the applicable state licensing board or any other accrediting body.

(h) Perform ten (10) chart reviews per month and participate in face-to-face meetings with the collaborated/supervised APC with the respective date and signature of both parties documented on the logs provided. The logs are to be kept by the APC.

(i) Be available for appropriate supervision of the AHP in accordance with these Bylaws and upon request of AHP.

(j) Physicians utilizing APCs must see their non-ICU patients within twenty-four (24) hours of admission or consultation. ICU admission and consults must be seen within 12 hrs by the attending physician. This does not negate the need for the APC to see the patient within a timely manner. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.

(k) Attending physicians may delegate initial ICU assessment to an Advanced Practice Clinician (APC). Advanced Practice Clinicians (APCs) are responsible for reviewing the case with the Attending Physician immediately following their initial assessment and documenting time and date in the medical record.

(l) If the patient remains unstable or becomes unstable after being initially evaluated by the Advanced Practice Clinician (APC), then it is the responsibility of the Attending Physician to do a bedside assessment within sixty (60) minutes of initial admission or transfer to the ICU.

- Failure to follow these responsibilities may result in restriction or loss of privileges for AHPs.
- AHPs may not be a substitute for physician call responsibilities.

H. Rules for Supervision of Residents

a. Residents are provided clinical rotations at the Hospital under the supervision of the attending medical staff. The management of each patient's care, treatment

and services is the ultimate responsibility of the licensed independent practitioner with appropriate clinical privileges. Residents may not independently diagnose, treat or discharge patients from the Hospital.

b. The parameters of medical practice and defined process for supervision for the Residents are defined within the Affiliation Agreements and/or the Program Letters of Agreement with the sponsoring educational facility.

c. PGY1 & PGY2 Residents may enter “Orders” without a co-signature, after consulting with and approval by the Attending Medical Staff. PGY3 & PGY4 Residents are able to enter “Orders” without the need of a co-signature by the Attending Medical Staff. All Resident “Notes” must be co-signed by the Attending Medical Staff.