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ARTICLE I

GENERAL

1.1. Definitions:

The definitions that apply to terms used in all the Medical Staff documents, including these Rules and Regulations, are set forth in the Medical Staff Bylaws.

1.2. Delegation of Functions:

(a) Unless otherwise provided, when a function is to be carried out by a member of Medical Center management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(b) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders will perform the function personally or delegate it to another appropriate individual.
ARTICLE II

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

2.1. Admissions:

(a) A patient may only be admitted to the Medical Center by order of a Medical Staff member who is granted admitting privileges.

(b) Patients will be admitted to the Medical Center on the basis of the following order of priority when there is a shortage of available beds:

1) Emergency

2) Urgent

3) Pre-operative

For all Medical Center admissions and observation placements, the Administrative Supervisor will be contacted to ascertain if there is a bed available or determine patient placement.

(c) Patients may be admitted to the Medical Center directly from their homes at the request of the attending physician. The physician requesting such admission shall notify the admitting office and submit an admitting order, in writing or by phone, before the patient arrives. Failure to provide an
admission order will result in the patient being assessed in the Emergency Department. If a patient who is being admitted from his or her home appears to be acutely ill or has symptoms that would require an urgent assessment, the admitting physician will be immediately notified and the patient will be admitted through the Emergency Department.

(d) Acutely psychotic patients, patients at risk of harming themselves or others, or patients hospitalized for alcohol or substance abuse should be evaluated for transfer to specialized facilities.

(e) All patients admitted to the Medical Center with a diagnosis of suicide attempt/overdose will be admitted to the Intensive Care Unit or to a private room with a sitter in attendance. The sitter will remain in attendance with the patient unless the attending physician deems the sitter unnecessary and writes an order to that effect. The sitter may not be a member of the patient's family unless specifically ordered by the attending physician.

(f) Patients that are admitted to the Medical Center who are emotionally ill and who also require stabilization for a medical condition/complication will be admitted until such time as they are medically stable. A psychiatric consult will then be considered.

(g) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible. A copy of the emergency service record will accompany the patient to the nursing unit.

2.2. Responsibilities of Attending Physician:

(a) The attending physician will be responsible for the medical care and treatment of the patient while in the Medical Center, including appropriate communication among the individuals involved in the patient’s care, the
prompt and accurate completion of the portions of the medical record for which he or she is responsible, and necessary patient instructions.

(b) Whenever the responsibilities of the attending physician are transferred to another physician, a note covering the transfer of responsibility will be entered on the order sheet of the patient’s medical record. The attending physician will summarize the patient’s condition and treatment in a progress note and will be responsible for verifying the other physician’s acceptance of the transfer.

(c) The attending physician will provide the Medical Center with any information concerning the patient that is necessary to protect the patient, other patients or Medical Center personnel from infection, disease or other harm, and to protect the patient from self-harm.

(d) The attending physician will abide by the Medical Center’s Utilization Review Plan, including guidelines on appropriateness and medical necessity of admissions, continued stays, supportive services and discharge planning.

2.3. Care of Unassigned Patients:

An “unassigned patient” means any individual who comes to the Medical Center for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Medical Center. All unassigned patients will be given the opportunity to select a member of the Medical Staff to be responsible for the patient while in the Medical Center. If the patient selects a dentist as his or her responsible practitioner, a physician will be assigned to assume medical responsibility for the patient. When no selection is made or where the selected physician is unavailable, the unassigned patient will be assigned to the appropriate on-call physician or to the Hospitalist service.
2.4. Availability and Alternate Coverage:

(a) Physicians will provide professional care for their patients in the Medical Center by being personally available, or by making arrangements with an alternate member who has appropriate clinical privileges to care for their patients.

(b) Except where directly admitted from the attending physician's office, the attending physician (or his or her alternate) must personally see the patient within 12 hours of admission. Once admitted, the attending physician (or his or her alternate) must personally see the patient at least daily and make appropriate progress notes in the medical record. In addition, the attending physician (or his or her alternate) or the appropriate physician consultant will comply with the following patient care guidelines regarding availability:

(1) Pages from the Emergency Department and/or a Patient Care Unit – must respond by telephone within 15 minutes of being paged and, if requested, must personally see a patient at the Medical Center within 30 minutes of the request in accordance with the Medical Center’s EMTALA – Texas Provision of On-Call Coverage Policy;

(2) Patients Admitted from the Emergency Department – must personally see the patient within 12 hours of admission;

(3) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission;

(4) ICU Patients – must personally see the patient within four hours of being admitted to the ICU, unless the patient’s condition requires that the physician see him or her sooner;
(5) Critical Care Consults – must be completed within 12 hours of the request, unless the patient’s condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., “stat,” “urgent,” “today,” or similar terminology – must also include personal contact by the requesting individual to the consulting physician);

(6) Routine Consults – must be completed within 24 hours of the request; and

(7) Patients Subject to Restraints or Seclusion – pursuant to Medical Center policy.

(c) If an attending physician does not participate in an established call coverage schedule with known alternate coverage and is unavailable to care for a patient, or knows that he or she will be out of town, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability.

(d) If an attending physician or his or her alternate is not available, the Chief Executive Officer or the Chief of Staff will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.5. Continued Hospitalization:

(a) The attending physician will provide whatever information may be requested by the Utilization Management Department with respect to the continued hospitalization of a patient, including:
(1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient’s diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the Medical Center; and

(3) plans for post-hospital care.

This response will be provided to Utilization Management within 24 hours of the request. Failure to comply with this requirement will be reported to the Medical Executive Committee for appropriate action.

(b) If the Utilization Management Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Medical Center, the patient, and the attending physician. If the matter cannot be appropriately resolved, the Chief of Staff will be consulted.
ARTICLE III

MEDICAL RECORDS

3.1. General:

(a) The attending physician will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(b) Only the following authorized individuals may make entries in the medical record: members of the medical staff, allied health professionals with appropriate clinical privileges, nursing personnel, dieticians, physical therapists and other rehabilitation specialists, laboratory technicians, radiology technicians, social workers, respiratory therapists and pharmacists.

(c) All handwritten entries will be legible in blue or preferably black ink. All entries must be timed, dated, and authenticated.

(d) Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Executive Committee will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file in the HIM Department.

3.2. Access and Retention of Record:

(a) The Medical Center will retain medical records in their original or legally reproduced form for a period consistent with Texas State Guidelines. If a
patient is younger than 18 years of age at the time he or she was last treated, the Medical Center may authorize the disposal of those medical records relating to the patient on or after the date of his or her 20th birthday or on or after the 10th anniversary of the date on which he or she was last treated, whichever date is later.

(b) Medical records are the physical property of the Medical Center. Original medical records may only be removed from the Medical Center in accordance with federal or state laws.

(c) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Medical Center policy.

(d) A patient or his or her duly designated representative may receive copies of the patient’s completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient.

(e) Access to all medical records of patients will 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 will be approved by the Institutional Review Board (IRB).

(f) Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Medical Center.

3.3. Content of Record:
(a) Medical records will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(b) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Medical Center's policies and procedures. Stamped signatures are not permitted in the medical record.

(c) All medical records will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the attending physician and the Medical Center:

(1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(2) patient's language and communication needs;

(3) evidence of informed consent when required by Medical Center policy and, when appropriate, evidence of any known advance directives;

(4) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(5) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
(6) admitting history and physical examination;

(7) conclusions or impressions drawn from the history and physical examination;

(8) diagnosis, diagnostic impression, or conditions;

(9) reason(s) for admission of care, treatment, and services;

(10) goals of the treatment and treatment plan;

(11) diagnostic and therapeutic orders;

(12) diagnostic and therapeutic procedures, tests, and results;

(13) progress notes made by authorized individuals;

(14) reassessments and plan of care revisions;

(15) relevant observations;

(16) response to care, treatment, and services provided;

(17) consultation reports;
(18) allergies to foods and medicines;

(19) medications ordered or prescribed;

(20) medications administered in the Medical Center (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(21) known long-term medications being taken by the patient, including current medications, over-the-counter drugs, and herbal preparations;

(22) medications dispensed or prescribed on discharge;

(23) relevant diagnoses/conditions established during the course of care, treatment, and services;

(24) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;

(25) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;

(26) final diagnosis; and

(27) whether the patient left against medical advice.
(d) For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. A summary list must be initiated for the patient by his or her third visit. This documentation will be the joint responsibility of the attending physician and the Medical Center:

1. known significant medical diagnoses and conditions;

2. known significant operative and invasive procedures;

3. known adverse and allergic drug reactions; and

4. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

(e) Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Medical Center:

1. identification data, including the patient’s name, sex, address, date of birth, and name of authorized representative;

2. time and means of arrival;

3. record of care prior to arrival;
(4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(5) description of significant clinical, laboratory or x-ray findings;

(6) results of the Medical Screening Examination;

(7) treatment given and plans for management;

(8) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care; and

(9) whether the patient left against medical advice.

3.4. History and Physical:

The requirements for histories and physicals, including general documentation and timing requirements, are contained in Appendix A of the Medical Staff Bylaws.

3.5. Progress Notes:

(a) Progress notes will be written by the attending physician or his or her covering practitioner. They may also be written by allied health professionals as permitted by their clinical privileges or scope of practice. When appropriate, each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.
(b) Progress notes will be legibly written, dated, timed, and authenticated by an attending physician at least daily for all patients who have been admitted to the Medical Center.

3.6. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using unique electronic signatures within the Medical Center’s electronic health record.

(b) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Medical Center policy.

(c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

(a) A general consent form, signed by or on behalf of every patient admitted to the Medical Center will be obtained at the time of admission. The medical record will contain evidence of the informed consent for procedures and treatments when required.

(b) The attending physician will be responsible for obtaining a patient’s informed consent. It is the policy of the Medical Center of Lewisville that consent be obtained in writing prior to performing any surgical procedures, non-surgical invasive, diagnostic and/or therapeutic procedures, intravenous injection of contrast material, central line insertions and all
procedures in which anesthesia or sedation is used. The consent will comply with the standards established by the Texas Medical Disclosure Panel. As a part of this process, the attending physician should discuss any potential risks and benefits, potential complications, any alternative options and the need for, risks and alternatives to, transfusion of blood or blood components, with the patient.

(c) When consent is not obtainable, the reason will be entered in the patient’s medical record.

3.8. Delinquent Medical Records:

(a) It is the responsibility of the attending physician to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Medical Center.

(b) A medical record is considered delinquent when:

(1) the History and Physical is not documented (written or dictated) within 24 hours of admission or prior to surgery, whichever comes first;

(2) the operative/procedure notes (written and dictated) are not documented immediately following surgery (i.e., upon completion of the operation or procedure but before the patient is transferred to the next level of care); or

(3) all required patient reports are not written, dictated and/or signed within 30 days of the patient’s discharge.
(c) The HIM Director will notify the attending physician whenever a medical record remains incomplete 15 days following discharge. If the record remains incomplete at 30 days, the physician will be notified in writing that his or her clinical privileges have been automatically relinquished in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the physician's records are no longer delinquent.

(d) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(e) When a physician is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the physician's credentials file and divulged in response to any future credentialing inquiry concerning the physician.

(f) Any requests for special exceptions to the above requirements will be submitted by the physician to the medical records department and considered by the Medical Executive Committee.

(g) A medical record will not be permanently filed until it is completed by the responsible physician, or it is ordered filed by the Medical Executive Committee. Except in rare circumstances, and only when approved by the Medical Executive Committee, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.
4.1. General:

(a) All written orders will be dated, timed, and authenticated at the time of entry by the ordering practitioner.

(b) Orders will be entered clearly, legibly, and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

(c) All orders for imaging studies will include the pertinent clinical indications.

(d) Orders for tests and therapies will be accepted only from:

(1) members of the Medical Staff;

(2) allied health professionals who are granted clinical privileges by the Medical Center, to the extent permitted by their licenses; and

(3) other individuals not on the Medical Staff who have been granted permission to order services pursuant to Medical Center policy.
(e) The use of the terms “renew,” “repeat,” “resume,” and “continue” with respect to previous medication orders is not acceptable.

(f) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be rewritten in the same format in which it was originally recorded if it is to be continued.

(g) Orders for all medications and treatments will be under the supervision of the attending physician and will be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

(h) No order will be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

(i) All orders for medications administered to patients will be:

1. reviewed by the attending physician at least weekly to assure the discontinuance of all medications no longer needed;

2. canceled automatically when the patient goes to surgery; and

3. reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is written when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.
(j) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be rewritten. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(k) Allied health professionals may be authorized to write medical and prescription orders as specifically delineated in their privileges that are approved by the Medical Center.

(l) All orders, history and physical examinations and pre-operative notes written by a physician assistant or advanced nurse practitioner will be countersigned/authenticated by the supervising physician by the close of the medical record.

4.2. Verbal Orders:

(a) A verbal order (via telephone or in person) for medication or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the responsible practitioner.

(b) All verbal orders will include the date and time of entry into the medical record, will be written in blue or preferably black ink, and will identify the names of the individuals who gave, received, and implemented the order, and then be authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Medical Center policy.
(c) For verbal orders, or for the reporting of critical test results over the telephone, the complete order or test result will be verified by having the person receiving the information record and “read-back” the complete order or test result.

(d) All verbal orders will be countersigned/authenticated with date and time by the ordering physician, or a practitioner who is also involved in the patient’s care in the Medical Center, within 48 hours.

(e) The following are the personnel authorized to receive and record verbal orders:

1. a registered nurse;

2. a licensed vocational nurse;

3. a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

4. a radiology or nuclear medicine technician who may transcribe a verbal order pertaining to tests and/or therapy treatments in his or her specific areas of expertise;

5. a laboratory technician who may transcribe a verbal order pertaining to tests in his or her specific areas of expertise;

6. a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
(7) a physical therapist and other rehabilitation therapists who may transcribe a verbal order pertaining to physical therapy treatments;

(8) a registered dietician who may transcribe a verbal order pertaining to diet and nutrition; and

(9) a social worker or chaplain who may transcribe a verbal order in his or her specific areas of expertise.

With the exception of special procedures, designated ancillary Radiology personnel may take verbal orders from physicians for outpatient diagnostic procedures.

4.3. Standing Orders, Order Sets, and Protocols:

(a) The Medical Executive Committee (or its designee) will review and approve any written protocol(s) to be utilized in the Medical Center for drugs or biologicals or other forms of treatment, and the circumstances in which a protocol would apply. Where appropriate, input should be sought from nursing and pharmacy.

(b) Prior to approval, the Medical Executive Committee will confirm that the standing order, order set, or protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols.

(c) When used, standing orders, order sets, and protocols must be dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or by another practitioner responsible for the care of the patient.
4.4. Orders for Drugs and Biologicals:

(a) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Medical Center.

(b) All orders for medications and biologicals will be in writing, dated, timed and authenticated by the practitioner responsible for the care of the patient, with the exception of influenza and pneumococcal vaccines, which may be administered per Medical Center policy after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Medical Center policies.

4.5. Orders for Radiology and Diagnostic Imaging Services:

(a) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Medical Center.

(b) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

4.6. Orders for Respiratory Care Services:

(a) Respiratory care services may be ordered by a qualified and licensed practitioner who is responsible for the care of the patient, either
independently or working in conjunction with a member of the Medical Staff.

(b) Orders for respiratory care services must include: (i) the patient’s name; (ii) the name and signature of the ordering individual; (iii) the type, frequency, and, if applicable, duration of treatment; (iv) the type and dosage of medication and diluents; and (v) the oxygen concentration or oxygen liter flow and method of administration.
ARTICLE V

CONSULTATIONS

5.1. General:

(a) Any individual with clinical privileges at the Medical Center shall provide consultations within his or her area of expertise, as required by the Medical Staff category to which he or she is assigned. When requested to do so, individuals who are on call for unassigned patients shall also provide inpatient consultations for which they are qualified. They may refuse to provide a consultation only in the following circumstances.

1. the patient in question has previously initiated a lawsuit against the individual on call, or the individual on call believes that such a lawsuit is reasonably likely given his or her relationship with the patient;

2. the patient has previously been discharged from practice of the individual on call;

3. the individual on call has previously been dismissed by the patient;

4. the patient indicates a preference for another consultant; or

5. other factors indicate that there is a conflict between the individual on call and the patient such that the individual on call should not provide consultation.

If the individual on call for unassigned patients is unable to provide consultation based on the aforementioned criteria (paragraph (a), 1-5), then the attending physician should find an alternate consultant. If the attending is unable to do so, then the department chair can appoint an alternate consultant. If the chair is unsuccessful, then the Chief of Staff can assist in appointing an alternate consultant.
(b) The attending physician is responsible for requesting a consultation when one is indicated and for personally contacting the appropriate consultant to discuss the patient’s condition and time frame in which the consult is needed. It is not the responsibility of any Medical Center employee to call a consultant on behalf of the attending physician or to relay an order for consultation.

(c) Except in an emergency, requests for a consultation will be entered as an order in the patient’s medical record. The order will include the following information: (i) who is being consulted; (ii) patient diagnosis and what the consult is related to; and (iii) the time frame in which the consult is needed. If the history and physical is not part of the patient’s medical record, it will be the responsibility of the attending physician to provide this information to the consultant.

(d) The consulting physician must generally respond within the guidelines outlined in Section 2.4(b) of these Rules and Regulations or within the time frame agreed upon with the attending physician.

(e) If a nurse employed by the Medical Center has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify his or her nursing supervisor who, in turn, will contact the attending physician. The nursing supervisor may then bring the matter to the attention of the Department Chair in which the member in question has clinical privileges. Thereafter, the Department Chair or Chief of Staff may request a consultation after discussion with the attending physician.

(f) In circumstances of grave urgency, or where consultation is required by these Rules and Regulations, or where a consultation requirement is imposed by the Medical Executive Committee, the appropriate Department Chair will at all times have the right to call in a consultant or consultants.
5.2. Content of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain a dictated or legible written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient’s medical record. A statement, such as “I concur,” will not constitute an acceptable consultation report. The consultation report will be made a part of the patient’s medical record.

(b) When non-emergency operative procedures are involved, the consultant’s report will be recorded in the patient’s medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.3. Required Consultations:

(a) Except in emergencies, consultations are required in all cases which, in the judgment of the attending physician:

(1) major surgical cases where the patient is a poor candidate for the operation or treatment;

(2) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(3) there is doubt as to the best therapeutic measures to be used;

(4) unusually complicated situations are present that may require specific skills of other practitioners; or
(5) the patient exhibits severe symptoms of mental illness or psychosis.

(b) Consultations are also required in the following circumstances:

(1) whenever requested by the patient or family, or the patient’s representative if the patient is incompetent;

(2) when indicated for the clinical specialty in admission to special care units;

(3) prior to patients receiving dialysis; or

(4) prior to patients receiving chemotherapy.

(c) All patients admitted to the ICU with an admit status level defined as intensive/critical care must have a consult with a hospital intensivist.

5.4. Mental Health Consultations:

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient’s medical record.

5.5. Surgical Consultations:
Whenever a consultation (medical or surgical) is requested prior to surgery, a written notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation is not available for review, surgery and anesthesia will not proceed.

5.6. Mandatory Consultations:

(a) When, as a result of professional practice evaluation activities, a consultation requirement is established by the Professional Activities Committee, the Medical Executive Committee, or the Board, the required consultation will not be rendered by an associate or partner of the attending physician unless this is specifically permitted when the consultation requirement is established.

(b) Failure to obtain required consultations may result in a further professional review action.
ARTICLE VI

SURGICAL SERVICES

6.1. Scheduling:

(a) The rules for the scheduling of elective and non-emergency surgery will be as follows:

(1) The schedule is available for posting cases at all times.

(2) The following information is required to post a case:

(i) patient’s full name, age, and sex;

(ii) planned surgical procedure;

(iii) type of anesthesia;

(iv) anesthesia personnel;

(v) operating surgeon; and

(vi) the title and name of the person posting the case.
(3) The order of cases will be based on the time of the cases posted, available operating room personnel, room equipment, etc., as determined by the operating room leadership.

(4) If cleared in advance with the operating room leadership, cases may be posted at a specified time or for justifiable reason, or if they do not interfere with the normal operating room schedule.

(b) In the event of an overly long delay due to unexpected circumstances, those directly affected in the cases to follow shall be notified. Those notified shall include the surgeons, anesthesiologists, first assistants, floor nurses prepping scheduled patients, and others who might be affected.

6.2. Pre-Procedure Protocol:

(a) Except in emergencies, the physician responsible for the patient’s care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any indicated diagnostic tests; (ii) the appropriate, properly executed surgical and anesthesia informed consents; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies. If the above information is not available, in a non-emergent situation, the responsible nurse will notify the responsible physician that preparation for surgery, including pre-medication, will not begin until all proper entries are recorded in the medical record. If this delay causes a change to be made to the surgery schedule, the operation will be rescheduled to the next available time.

(b) In the case of an emergency, the responsible physician will take the following steps before starting the surgery: (i) state in writing that a delay would be detrimental to the patient and (ii) make a note in the medical record indicating the patient’s condition prior to the induction of anesthesia.
(c) The following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

(1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(3) the attending physician is in the Medical Center;

(4) the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol; and

(5) if the operating surgeon is of the opinion that the procedure involves an unusual hazard to life, a qualified surgeon is present and scrubbed in as first assistant.

(d) A staff appointee who is classified in a preceptorship or supervisory status for specified surgery privileges must have present his or her preceptor or qualified assistant for these specified surgery procedures.

6.3. Post-Procedure Protocol:

(a) For every procedure performed in an operating room and/or under sedation, a progress note containing the following information will be entered in the medical record immediately after the procedure:
(1) pre-operative diagnosis;

(2) post-operative diagnosis;

(3) procedures performed;

(4) findings;

(5) specimen(s) removed;

(6) estimated blood loss;

(7) type of anesthesia;

(8) complications; and

(9) name of surgeon(s)/assistant surgeon(s).

(b) A full operative procedure report for these invasive procedures will then be dictated or legibly handwritten within 24 hours of the procedure, and authenticated by the attending physician. The report will record:

(1) pre- and post-operative diagnoses;

(2) date and time of the procedure;
(3) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient’s operation;

(4) procedure(s) performed and description of the procedure(s);

(5) description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;

(6) findings;

(7) estimated blood loss;

(8) any unusual events or complications, including blood transfusion reactions and the management of those events;

(9) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

(10) specimen(s) removed, if any; and

(11) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

6.4. Surgical Specimens:

(a) Unless otherwise exempt, all specimens removed during a surgical procedure will be properly labeled and immediately sent to the laboratory for examination by the pathologist. The specimen will be accompanied by
pertinent clinical information, including: preoperative diagnosis and history, procedure, specimen, and postoperative diagnosis. The pathological report will be made a part of the patient’s medical record.

(b) The following classes of specimens are exempt from examination by a pathologist:

1. bone donated to the bone bank and bone segments removed as a part of corrective or reconstructive orthopedic procedures;

2. cataracts removed by phycoemulsification;

3. dental appliances;

4. fat removed by liposuction;

5. foreign bodies (e.g., bullets) that for legal reasons are given directly to law enforcement representatives;

6. foreskin from newborn circumcisions (not adults);

7. intrauterine contraceptive devices without attached soft tissues;

8. medical devices, such as catheters, gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to the patient’s illness, injury or death;

9. middle ear ossicles;
(10) orthopedic hardware and other radiopaque mechanical devices, provided there is an alternative policy for documentation;

(11) grossly normal placentae;

(12) orthopedic appliances, foreign bodies, synthetic materials, portions of rib removed to enhance operative exposure;

(13) saphenous vein segments harvested for coronary artery bypass;

(14) skin or other tissue removed during cosmetic or reconstructive procedures;

(15) teeth without attached soft tissues; and

(16) therapeutic radioactive sources grossly unremarkable.

(c) All specimens removed at operation and all specimens obtained from a patient will be the property of the Medical Center.
ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

(a) General and Regional Anesthesia (including epidurals/spinals) may only be administered by an anesthesiologist.

(b) Moderate or deep sedation may be administered by the following qualified practitioners:

(1) an anesthesiologist; or

(2) an M.D. or D.O. (other than an anesthesiologist).

(c) “Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal or conscious sedation, or analgesia via epidurals/spinals for labor and delivery.

(d) Because it is not always possible to predict how an individual patient will respond to moderate sedation anesthesia, a qualified practitioner must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.
(e) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

(b) The evaluation will be recorded in the medical record and will include:

1. a review of the medical history, including anesthesia, drug and allergy history;

2. an interview and examination of the patient;

3. notation of any anesthesia risks;

4. identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

5. development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and
any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

(c) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

(a) All patients will be monitored during the procedure and/or administration of anesthesia at a level consistent with the potential effect of the procedure and/or anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient’s physiological status.

(b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(1) the name and hospital identification number of the patient;

(2) the name of the practitioner who administered anesthesia;

(3) the name, dosage, route, time, and duration of all anesthetic agents;
(4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(5) the name and amounts of IV fluids, including blood or blood products, if applicable;

(6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(7) any complications, adverse reactions or problems occurring during anesthesia and the patient’s status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations:

(a) A post-anesthesia evaluation will be completed and documented in the patient’s medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(b) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient’s medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient’s inability to participate will be made in the medical record.

(c) Where post-operative sedation is necessary for the optimum care of the patient, the evaluation can occur in the PACU/ICU or other designated
recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient’s discharge. The evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation.

(d) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(1) respiratory function;

(2) cardiovascular function;

(3) mental status;

(4) temperature;

(5) nausea and vomiting; and

(6) postoperative hydrations.

(e) Patients will be discharged from the recovery area by a qualified practitioner or according to criteria approved by the clinical leaders. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(f) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
When surgical or anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

7.5. Minimal Sedation:

All patients receiving minimal sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

7.6. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.
8.1. General Rules Regarding Obstetrical Care:

(a) Informed consent for the delivery will be obtained by the physician.

(b) All obstetric patients who undergo caudal, spinal saddle block or epidural anesthesia should have an I.V. started prior to the administration of the anesthesia.

(c) All previous orders will be cancelled after a caesarean section or postpartum tubal ligation.

8.2. Obstetrical Care Medical Records:

The current obstetrical record will include a prenatal record. All obstetrical medical records will have complete prenatal histories, physical examinations and discharge summary. The prenatal record may be a legible copy of the attending physician’s office record transferred to the Medical Center that includes up-to-date findings since the time of the last visit. The obstetrical record will also include a short obstetrical history and physical form which will be filled out by the physician upon patient admission.

8.3. Newborn Care:
(a) Every newborn shall be examined at the time of delivery and the following noted on his or her medical record:

(1) condition at birth including APGAR score or its equivalent;

(2) time of sustained respirations;

(3) any physical abnormalities or pathological states; and

(4) any evidence of distress.

(b) Each newborn shall have a complete physical examination by a physician within twenty-four (24) hours after birth, and the results of the examination shall be recorded in the newborn’s medical record. The record of the newborn shall accompany him or her from the place of delivery to the nursery or couplet care area. This record shall include information concerning prenatal history, course of labor, delivery, drug administration to mother and newborn, relevant conditions of the mother, procedures performed on the newborn in the delivery room, complications of any type, and other facts and observations. A complete medical record for every newborn should include the following information:

(1) obstetrical history of mother’s previous pregnancies;

(2) description of complications of pregnancy, labor or delivery;

(3) list of complicating maternal diseases;

(4) drugs taken by the mother during pregnancy, labor and delivery;
(5) duration of ruptured membranes;

(6) maternal antenatal blood serology, rubella titer, blood typing, Rh factors, and, where indicated, a Coombs test for maternal antibodies, and any other tests deemed appropriate;

(7) description of labor progress and operative procedures, including reasons for operative procedures, if any, signed by the attending physician or authorized delegate;

(8) anesthesia, analgesia and medications given to mother and newborn;

(9) condition of newborn at birth, including the one- and five-minute APGAR Score or its equivalent, resuscitation, time of sustained respirations, details of physical abnormalities, pathological states observed and treatments given before transfer to the nursery;

(10) any observed abnormalities and pathology report of examination of the placenta and cord vessels;

(11) date and hour of birth, birth weight and length, and period of gestation;

(12) a written verification of eye prophylaxis;

(13) report of initial physical examination, including any abnormalities signed by the attending physician or authorized delegate;
(14) discharge physical examination, including head and chest circumference and body length and weight, unless previously done, and recommendations and signature of attending physician or designee;

(15) a listing of all diagnoses since birth, including discharge diagnosis; and

(16) specific follow-up plans for care of newborn.

(c) All physicians caring for newborns shall be responsible for obtaining appropriate consultations for conditions or treatment procedures for which they have not been granted clinical privileges. A consultation from a neonatologist is required for any newborn or infant with significant respiratory distress or any other complication or condition that appears to be life-threatening.

(d) All newborn orders must be itemized and signed by the ordering physician, including orders for formula and care of the newborn.

(e) Tests for phenylketonuria (PKU) and other metabolic diseases of the newborn that may lead to mental retardation or physical defects shall be performed by the attending physician as required by law at the time of discharge or transfer. The results of such tests shall be made part of the newborn's medical record. If the baby is discharged before forty-eight (48) hours of age, a repeat outpatient screen will be ordered.

8.4. Termination of Pregnancy:
There will be no elective termination of pregnancies performed at the Medical Center.
9.1. General Rules:

(a) Orders for drugs and biologicals are addressed in Article IV.

(b) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.

(c) Transfusion reactions, adverse medication reactions, and errors in administration of medications will be immediately documented in the patient’s medical record and reported to the attending physician and, if appropriate, to the appropriate departments and individuals within the Medical Center.

(d) Self-medication by patients will not be permitted, unless written in the orders by the attending physician. The order must include the patient’s name and direction for administration. The medication must be properly labeled with the patient’s name, directions for administration and stored in the medication room. Controlled substances brought to the Medical Center will not be left with the patient and must be secured in the pharmacy until the patient is discharged.

(e) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.
(f) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, the American Hospital Formulary Service or the AMA Drug Evaluations.

(g) The use of investigational or experimental drugs in clinical investigations will be in accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

(h) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Medical Center staff.

9.2. Storage and Access:

(a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Medical Center policy, consistent with federal and state law.

(1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(3) Only authorized personnel may have access to locked areas.
(b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

9.3. Self-Administration of Medications:

(a) The self-administration of medications (either hospital-issued or those brought to the Medical Center by a patient) will not be permitted unless:

(1) the patient (or the patient’s caregiver) has been deemed capable of self-administering the medications;

(2) a practitioner responsible for the care of the patient has issued an order for their administration;

(3) in the case of a patient’s own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and

(4) the patient’s first self-administration is monitored to determine whether additional instruction is needed on the safe and accurate administration of the medications.

(b) The self-administration of medications will be documented in the patient’s medical record as reported by the patient (or the patient’s caregiver).

(c) All self-administered medications (whether hospital-issued or the patient’s own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.
(d) If the patient’s own medications brought to the Medical Center are not allowed to be self-administered, the patient will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient’s representative at the time of discharge from the Medical Center.

9.4. Stop Orders:

A physician is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Specific drugs (e.g., Ketorolac) are limited by maximum number of days or doses and will not exceed warnings or guidelines. Other medications not specifically prescribed as to time or number of doses will be subject to “STOP” orders and automatically discontinued as follows:

(a) all antibiotics and steroids after seven days;

(b) Schedule II controlled substances after 10 days;

(c) Schedules III-V controlled substances after 30 days;

(d) all chronic antiviral medications and antituberculosis medications after 30 days; and

(e) all other drugs after 30 days.

The prescribing physician will be notified according to Medical Center policies and procedures within 12 hours before an order is automatically stopped. No medications will be discontinued without first notifying the physician.
ARTICLE X

RESTRAINTS AND SECLUSION

Restraints and seclusion will be governed by the Medical Center’s Restraints and Seclusion Policy Number 911.303.
ARTICLE XI

EMERGENCY SERVICES

11.1. General:

(a) Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care.

(b) Emergency services and care will be provided without regard to the patient’s race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

(c) An appropriate record or log will be kept in the Emergency Department, listing every person who presents to the Emergency Department for treatment or care. The log will be updated with a notation concerning treatment or transfer, as applicable.

11.2. Emergency Services:

(a) A physician on-call roster will be maintained in the Emergency Department in accordance with the Medical Center’s policies and procedures.
(b) It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Medical Center's EMTALA – Texas Provision of On-Call Coverage Policy and the Medical Staff Bylaws.

(c) At least one emergency physician will be in the Medical Center and immediately available for rendering emergency patient care 24 hours per day, seven days per week.

(d) The physician Director of the Emergency Department will have overall responsibility for emergency care, subject to the authority of the Board, and will approve Emergency Department policies and procedures.

(e) The Director of the Emergency Department will ensure that Emergency Department procedures are properly coordinated with the Medical Center's disaster plan, especially as they relate to the care of mass casualties.

11.3. Medical Screening Examinations:

(a) Medical screening examinations, within the capability of the Medical Center, will be performed on all individuals who come to the Medical Center requesting examination or treatment to determine the presence of an emergency medical condition. The Board has approved the following qualified medical personnel ("QMPs") to perform medical screening examinations in the Medical Center's Emergency Department: physicians, LIPs, physician assistants, nurse practitioners and nurse midwives. Registered Nurses who are not Advance Practice Nurses are not permitted to perform medical screening examinations in the Emergency Department.

(b) In certain circumstances, the Board and Medical Staff have determined that a Labor and Delivery Nurse who has successfully completed
orientation and required competency validations is qualified to assess the patient and report findings to the obstetrician who will then make a determination if an emergency medical condition exists.

(c) Whenever the medical screening examination is performed by a non-physician/non-LIP, the medical screening examination will be performed in accordance with specific screening guidelines, protocols and algorithms, as approved by the Medical Staff/Medical Executive Committee, that outline the examination or diagnostic work-up required to determine if an emergency medical condition exists.

(d) The results of the medical screening examination must be documented or dictated within 48 hours of the conclusion of an Emergency Department visit.

11.4. Admissions and Transfers:

(a) Patients who require specialty or subspecialty physician care that is not available within a reasonable time at the Medical Center will be transferred to another hospital pursuant to applicable Medical Center policies and procedures.

(b) If a patient needs to be admitted to the Medical Center as an inpatient, either for observation or further treatment, the patient will be admitted by the attending physician.

(c) A transfer of a patient that occurs after the completion of the medical screening examination will be initiated in accordance with Medical Center Policy 911-500.003 entitled EMTALA – Texas Transfer Policy of Patients Between Hospitals With or Without Emergency Medical Conditions.
11.5. X-Ray Interpretations:

The emergency physician will arrange for an interpretation of x-rays by a radiologist and comparison of initial and final x-ray interpretations. In cases where an x-ray interpretation of the radiologist is significantly different from that initial made by the emergency physician, the radiologist will notify the emergency physician or the patient’s private physician as soon as possible, and copies of the radiologist’s report will be made available to the emergency physician and the patient’s private physician.

11.6. Emergency Department Medical Records:

(a) The medical records of patients who have received emergency care will be signed by the Emergency Department physician in attendance, who will be responsible for their clinical accuracy.

(b) The Director of the Emergency Department will coordinate the review of Emergency Department records with the responsible medical staff committee.
ARTICLE XII

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

12.1. Who May Discharge:

(a) Patients will be discharged only upon the written order of the attending physician. Should a patient insist on leaving the Medical Center against medical advice, or without proper discharge, a notation of the incident will be made in the patient’s medical record, and the patient will be asked to sign the Medical Center’s AMA (against medical advice) form.

(b) At the time of discharge, the attending physician will review the record for completeness, state the principal and secondary diagnosis (if one exists) and authenticate the entry.

(c) The attending physician will make an effort to write discharge orders that will allow patients to be discharged from the Medical Center by noon on the day of discharge.

12.2. Identification of Patients in Need of Discharge Planning:

(a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization.

(b) Criteria to be used in making this evaluation include:
(1) functional status;

(2) cognitive ability of the patient; and

(3) family support.

12.3. Discharge Planning:

(a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient’s needs after hospitalization, will be documented in the patient’s medical record. The attending physician is expected to participate in the discharge planning process.

(b) When the Medical Center’s personnel determine no discharge planning is necessary in a particular case, that conclusion will be noted on the medical record of the patient.

(c) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

12.4. Discharge Summary:

(a) A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed within 30 days of discharge:
(1) reason for hospitalization;

(2) significant findings;

(3) procedures performed and care, treatment, and services provided;

(4) condition and disposition at discharge;

(5) information provided to the patient and family, as appropriate;

(6) provisions for follow-up care; and

(7) discharge medication reconciliation.

(b) For patient stays under 48 hours, a final legible progress note containing the outcome of the hospitalization, discharge instructions and provisions for follow-up care may be substituted for a discharge summary.

12.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.
12.6. Discharge Instructions:

(a) Upon discharge, the attending physician, along with the Medical Center staff, will educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

(b) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.

(c) The attending physician, along with the Medical Center staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

(d) When continuing care is needed after discharge, the attending physician, along with the Medical Center staff, will provide appropriate information to the other health care providers, including:

(1) the reason for discharge;

(2) the patient’s physical and psychosocial status;

(3) a summary of care provided and progress toward goals;

(4) community resources or referrals provided to the patient; and

(5) discharge medications.
ARTICLE XIII

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

13.1. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Medical Center to another facility, includes:

(a) assessing the reason(s) for transfer;

(b) establishing the conditions under which transfer can occur;

(c) evaluating the mode of transfer/transport to assure the patient’s safety; and

(d) ensuring that the organization receiving the patient assumes responsibility for the patient’s care after arrival at that facility.

13.2. Procedures:

(a) Patients will be transferred to another hospital or facility based on the patient’s needs and the Medical Center’s capabilities. The attending physician will take the following steps as appropriate under the circumstances:
(1) identify the patient’s need for continuing care in order to meet the patient’s physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, Medical Center staff, and family members involved in the patient’s care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

   (i) the reason for the transfer;

   (ii) the risks and benefits of the transfer; and

   (iii) available alternatives to the transfer.

(b) When patients are transferred, appropriate information will be provided to the accepting practitioner/facility, including:

   (1) reason for transfer;

   (2) significant findings;
(3) a summary of the procedures performed and care, treatment and services provided;

(4) condition at discharge;

(5) information provided to the patient and family, as appropriate; and

(6) working diagnosis.

(c) When a patient requests a transfer to another facility, the physician will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (b) above.

13.3. EMTALA Transfers:

Patients who come to the Emergency Department who require specialty or subspecialty care that is not available within a reasonable time at the Medical
Center will be transferred to another hospital in accordance with Article XI of these Rules and Regulations and all applicable Medical Center policies and procedures.
ARTICLE XIV

MISCELLANEOUS

14.1. Autopsies:

(a) The attending physician should attempt to secure autopsies in the following situations and in accordance with state and local laws:

(1) deaths in which an autopsy may help explain an unknown or unanticipated medical complication;

(2) deaths in which the cause of death is not known with certainty on clinical grounds;

(3) cases in which an autopsy may help to allay the concerns of, or provide reassurance to, the family or the public regarding the death;

(4) unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures or therapies; and

(5) all obstetrical deaths.

(b) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient’s death. The attending physician must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual
or if, in the opinion of the attending physician, an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this must be documented in the medical record.

(c) Any request for an autopsy by the family of a patient who died while at the Medical Center will be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient’s family or legal guardian. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer and/or the Chief of Staff.

(d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

14.2. Patient Deaths and Death Certificates:

(a) In the event of a patient death in the Medical Center, the deceased will be pronounced dead by the attending physician (or his or her designee), the Administrative Supervisor, Nursing Department Directors or Nursing Unit Managers, within a reasonable time frame. The attending physician may only designate the pronouncement of death to a Registered Nurse. However, a Registered Nurse may not pronounce death if an artificial means of support precludes the determination that a person’s spontaneous respiratory or circulatory functions have ceased (e.g., mechanical ventilation, pacemaker).

(b) Death certificates are the responsibility of the attending physician and will be completed within 24 hours of when the certificate is available to the attending physician.

(c) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient’s medical record by the attending
physician or other designated member of the Medical Staff. Policies with respect to release of dead bodies will conform to local law.

(d) All deaths which meet the criteria for Denton County reportable deaths will be reported to the Medical Examiner.

14.3. Medical Examiner Cases:

(a) It is the responsibility of the attending physician to notify the Medical Examiner of all deaths that meet the criteria outlined in Texas Penal Code, Article 49.25. A copy of Texas Penal Code, Article 49.25 will be maintained in the Administrative Supervisor’s office.

(b) The Medical Examiner will decide whether or not an autopsy must be performed. The attending physician will be notified when an autopsy is ordered by the Medical Examiner.

14.4. Organ Procurement:

The Organ Procurement Organization will be notified of all patient deaths to determine the potential for organ/tissue donation based on criteria. The appropriate patient representative will be contacted whenever a patient meets the criteria for donation eligibility.

14.5. Treatment of Family Members:

(a) No member of the Medical Staff will admit, treat or participate in the surgery of a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise approved by the Chief of Staff or
the Chief Executive Officer. This prohibition is not applicable to in-laws or other relatives.

(b) An exception to this prohibition will be made (1) if the patient’s disease is so rare or exceptional and the physician is considered an expert in the field or (2) in an emergency where no other Medical Staff member is readily available to care for the family member, and a transfer is believed to be detrimental to the patient’s health.

14.6. Orientation of New Physicians:

Each new physician will be provided an overview of the Medical Center and its operations. As a part of this orientation, the Medical Records Department and nursing service will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

14.7. Continuing Medical Education:

(a) All members of the Medical Staff are encouraged to participate in pertinent self-assessment programs and in basic cardio-pulmonary resuscitation training.

(b) Continuing education requirements for members of the Medical Staff will be in compliance with the requirements established by accreditation bodies and state licensing boards.

(c) Each practitioner with clinical privileges will participate in continuing education programs and in other continuing education activities that relate to the privileges granted.
(d) Continuing medical education programs will be based, at least in part, on the findings of the performance improvement program.

(e) Emergency physicians will maintain current certification in advanced cardiac life support.
ARTICLE XV

AMENDMENTS

An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to this document shall be provided to each member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee. Adoption of and changes to the Medical Staff Rules and Regulations will become effective only when approved by the Board.
ARTICLE XVI

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _________________________ (Date)_____

Approved by the Board: _____________________________ (Date)_____