



Texas Health

Harris Methodist Hospital

SOUTHLAKE

**MEDICAL STAFF
RULES AND REGULATIONS**

*1545 E. SOUTHLAKE BLVD.
SOUTHLAKE, TEXAS
76092*

CONTENTS

I.	INTRODUCTION -----	3
II.	ADMISSION AND DISCHARGE -----	4
III.	MEDICAL RECORDS -----	4
A.	Content of Medical Record -----	5
B.	History and Physical -----	5
C.	Pre-operative History and Physicals -----	6
D.	History and Physical Done in Physician's Office -----	6
E.	Documentation for Consultations -----	6
F.	Progress Notes -----	6
G.	Operative Reports -----	7
H.	Anesthesia -----	7
I.	Discharge Summary -----	9
J.	Final Diagnosis -----	9
K.	Autopsy -----	9
L.	Authentication of Medical Records -----	10
M.	Electronic Signature -----	10
N.	Facsimile Signatures -----	10
O.	Delinquent Medical Records -----	11
P.	Medical Records Access -----	11
Q.	Confidentiality and Security of Records -----	12
R.	Corrections -----	12
S.	Abbreviations, Acronyms, and Symbols -----	12
T.	Retirement of Records -----	12
IV.	ORDERS -----	13
V.	DRUGS AND MEDICATIONS -----	14
VI.	CONSULTATIONS -----	16
VII.	GENERAL REQUIREMENTS -----	16
VIII.	EMERGENCY SERVICES -----	20
IX.	SURGICAL CARE -----	21
	APPROVALS: -----	23
	ATTACHMENT A -----	25
	AUTHORIZED EXEMPT SPECIMEN LIST -----	25
	ATTACHMENT C -----	26
	LIST OF GOVERNING BODY APPROVED CATEGORIES FOR -----	26
	ALLIED HEALTH PROVIDERS -----	26

I. INTRODUCTION

These Rules and Regulations are established to govern the conduct of work of the Medical Staff of Harris Methodist Southlake Center for Diagnostics & Surgery. The Medical Executive Committee has been delegated the authority to adopt these rules and regulations with the final concurrence of the Board of Managers.

No regulations, rules or orders, may in any way conflict with any provisions of the Hospital or Medical Staff Bylaws or with any known law or regulation.

Rules and regulations will be reviewed at least triennially, in addition to continually improving or correcting them as time and circumstances may dictate.

For clarity and ease of reading, "Physician" is referred to in the male gender although the physician may be either male or female. In addition, all references to "he/him/his" throughout shall refer to both males and females.

II. ADMISSION AND DISCHARGE

1. A physician member of the medical staff shall be responsible for the care and treatment of each patient in the hospital. All patients shall have a complete history and physical performed and recorded in the medical record by a physician who is either a member of the medical staff or has been approved by the medical staff to do so. Dentists and podiatrists shall be responsible for recording in the medical record a history and physical examination relative to the dental or podiatric problem. Any medical problem present on admission or arising during the hospitalization of a dental or podiatric patient shall become the responsibility of a qualified physician.
2. Each member of the medical staff shall specify a member of the medical staff with appropriate privileges who will be available to attend his patients in an emergency. In case of failure to name such a practitioner, the president of staff, his/her designee or the hospital administrator (in order of availability) shall have authority to call any qualified member of the medical staff if necessary. Failure of a medical staff member to meet this requirement shall be reported to the medical staff executive committee via peer review for any action deemed appropriate.
3. Except as otherwise provided in hospital policies for utilization of intensive care and intermediate care beds, no patient will be transferred within the hospital without the approval of the responsible practitioner, with the exception of a harmful or infectious patient who needs immediate relocation to protect himself or others. In the latter case, the medical director and/or chief of staff will be contacted to approve move if the responsible physician is not available. The responsible practitioner shall be notified as soon as he can be reached.
4. When a patient is being transferred to another hospital, a nursing home, or other health care facility, the responsible practitioner or other individual authorized by hospital policy shall indicate the reason for transfer, the name of the receiving facility, the name of the accepting practitioner, and the status of the patient's stability and shall sign the inter-facility transfer documents.
5. Any patient evaluated in the emergency room or who is being admitted to or is already in the hospital and who is known or suspected to be suicidal, otherwise self-injurious, or has taken a chemical overdose shall have psychiatric consultation. If this consultation is refused by the patient or legally responsible other, the medical record shall indicate that the consultation was recommended, offered, and refused.
6. The patient shall be discharged only on the order of the responsible practitioner. If a patient leaves the hospital against medical advice (AMA), the patient or legally responsible other shall be requested to sign an AMA release statement. Whether or not such a statement can be obtained must be noted in the patient's medical record along with any reason given, and witnessed by a hospital staff member. An AMA release statement must indicate by the patient's or responsible other's signature that the patient is voluntarily leaving the hospital against the advice of the practitioner and that in so doing the patient absolves the practitioner and the hospital from any and all direct and indirect consequences even if they occur subsequently. A patient leaving the hospital on his own accord without signing the appropriate document(s) shall be considered to be officially discharged.

III. MEDICAL RECORDS

A. Content of Medical Record

1. The attending practitioner is responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.
2. The medical record contains the following clinical information:
 - The reason(s) for admission for care, treatment, and services
 - The patient's initial diagnosis, diagnostic impression(s), or condition(s)
 - Any findings of assessments and reassessments
 - Any allergies to food
 - Any allergies to medications
 - Any conclusions or impressions drawn from the patient's medical history and physical examination
 - Any diagnoses or conditions established during the patient's course of care, treatment, and services
 - Any consultation reports
 - Any observations relevant to care, treatment, and services
 - The patient's response to care, treatment, and services
 - Any emergency care, treatment, and services provided to the patient before his or her arrival
 - Any progress notes
 - All orders
 - Any medications ordered or prescribed
 - Any medications administered, including the strength, dose, and route
 - Any access site for medication, administration devices used, and rate of administration
 - Any adverse drug reactions
 - Treatment goals, plan of care, and revisions to the plan of care
 - Results of diagnostic and therapeutic tests and procedures
 - Any medications dispensed or prescribed on discharge
 - Discharge diagnosis
 - Discharge plan and discharge planning evaluation
 - any patient and/or family instructions and/or education
 - Autopsy protocols

B. History and Physical

1. A complete history and physical examination, performed by a physician member or approved by the medical staff, or by another individual approved for such privilege based on demonstrated competence must be recorded in the medical record prior to surgery.
2. For all elective surgery patients a history and physical must be recorded at the time of admission and prior to the procedure, unless an emergency situation exists.

C. Pre-operative History and Physicals

1. In cases where a complete history and physical is not present in the medical record, the clinical supervisor will request the admitting physician or if unavailable the surgeon to record a pertinent handwritten history and physical in the medical record prior to the induction of anesthesia.
2. Elective inpatient or outpatient surgery (to be performed under other than local anesthesia) will be cancelled or delayed until a pertinent history and physical examination is recorded in the medical record.
3. A medical history and physical examination be completed no more than 30 days prior to or within 24 hours after inpatient admission. For a medical history and physical examination that was completed within 30 days prior to inpatient admission, an update listing any changes in the patient's condition or a note stating "no significant changes", is to be completed within 24 hours after inpatient admission or prior to surgery, whichever comes first.

D. History and Physical Done in Physician's Office

1. History and physical done in the physician's office will be acceptable if the following Guidelines are met:
 - The examination must have been done within the previous seven (7) day period.
 - An interval note is recorded at the time of admission.
 - A durable, legible reproduction may be used. All illegible copies shall be subject to rejection and the physician's office notified immediately.
 - The physician will need to sign and date the copy.

E. Documentation for Consultations

1. Consultations shall show evidence or review of the patient's record by the consultant.
2. Pertinent findings on examination and the consultant's opinion and recommendations must be noted.
3. A limited statement such as "I concur" does not constitute an acceptable report of consultation.
4. Rules and Regulations by area shall specify situations in which consultation is required.

F. Progress Notes

1. The progress notes should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.
2. The patient's clinical problems should be clearly identified and correlated with specific orders as well as test, procedure, and treatment results.
3. Progress notes shall be written at least daily and more often when warranted by the patient's condition.

4. Progress notes shall be legible, dated, timed and signed.

G. Operative Reports

1. A preoperative diagnosis is recorded prior to surgery.
2. If a complete operative report is not placed in the medical record immediately after surgery, a post operative progress note, comprehensive enough to permit continuity of care, must be entered in the medical record at the time of completion of the procedure and prior to the patient going to the next level of care. The note shall contain:
 - name of the primary surgeon and assistant surgeons;
 - procedures performed;
 - a description of the findings;
 - estimated blood loss, as indicated;
 - any specimens removed; and
 - the postoperative diagnosis.

Note: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the immediate postoperative progress note may be written in the new unit or area of care.

3. Complete operative reports must be dictated in the medical record within 24 hours after surgery and shall contain:
 - name of the primary surgeon and assistant surgeons;
 - procedures performed and description of procedure;
 - a description of the findings;
 - estimated blood loss, as indicated;
 - any specimens removed; and
 - the postoperative diagnosis.
4. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

H. Anesthesia

1. A pre-anesthesia evaluation of the patient by an anesthesiologist must be documented in the medical record in all elective surgery cases prior to the patient's transfer to the operating area and before preoperative medication has been administered.
2. The pre-anesthesia evaluation will determine the capacity of the patient to undergo anesthesia and will formulate an anesthesia plan for the patient. This evaluation will include, but not limited to:
 - reference to the choice of anesthesia (general, conscious sedation, spinal, other regional, or standby);
 - the patient's allergies and any previous medication;
 - smoking;
 - alcohol use history;

- other anesthesia experiences;
 - any potential anesthetic problems;
 - plan for anesthesia; and
 - the anticipated location for post anesthesia recovery.
3. The patient's physical status should be categorized using the ASA classification of the American Society of Anesthesiologists. Surgical patients receiving anesthesia will be of ASA Physical Status levels of 1 through 4 as defined by the American Society of Anesthesiologists.
 4. The anesthesiologist shall record in the medical record:
 - evidence of pre-anesthesia check of the anesthesia machine;
 - monitoring equipment;
 - patient's physiological monitored vital signs;
 - level of consciousness;
 - all anesthesia drugs and agents to be used as well as all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents; and other drugs, intravenous fluids, and blood and blood components.
 5. There should be evidence in the medical record that patient discharge from the post-anesthesia recovery unit is based on a physician decision. This may be documented by:
 - a. a written physician order;
 - b. a recorded verbal physician order; or
 - c. the recovery / post anesthesia nurse's authorized indication of a physician approval based on the patient's attainment of approved discharge criteria.
 6. At least one post-anesthesia visit must be made after an inpatient has left the recovery area (recovery room, special care unit, designated room in nursing unit), at which time a dated and timed note is to be made in the medical record describing the presence or absence of anesthesia-related complications.
 7. [When the post-anesthesia visit and record entry by anesthesia personnel is not feasible because of early patient release from the hospital \(as may occur in same-day surgery\), the practitioner who discharges the patient from the hospital is responsible for the post-anesthesia note.](#)
 8. Medical record information from a post anesthesia recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area, the vital signs, medications administered, and when such are in use, the status of infusions, surgical dressings, tubes, catheters, and drains.
 9. General anesthesia will be administered only by an Anesthesiologist or CRNA. The "surgeon of record" and the "supervising anesthesiologist" cannot be one in the same when general anesthesia, requiring intubation, is given.
 10. Any physician or CRNA administering "moderate sedation" for a procedure must demonstrate competence as determined by the Credentials Committee upon appointment and/or reappointment to the Medical Staff.

I. Discharge Summary

1. A discharge summary shall be written or dictated on all medical records of patients hospitalized more than 48 hours.
2. A discharge summary is not required when a patient is seen for minor problems or interventions hospitalized less than 48 hours. In this instance, a final progress note may be substituted for the discharge summary.
3. The discharge summary shall include the following:
 - the reason for hospitalization;
 - the care, treatment, and services provided;
 - the procedures performed;
 - the patient's condition and disposition at discharge;
 - Information provided to the patient and family
 - Provisions for follow-up care
4. The condition of the patient on discharge shall be stated in terms that permit a specific measurable comparison with the condition on admission.
5. In the event of patient death, a summation statement shall be added to the record either as a final progress note or as a narrative summary, indicating:
 - the reason for admission;
 - the findings and course in the hospital;
 - events leading to death; and
 - cause of death.

The content of the medical record should be sufficient to justify the diagnosis and to warrant the treatment and hospitalization.

J. Final Diagnosis

1. Final diagnoses, complications and all other treated diagnosis and procedures shall be recorded in full and authenticated by the responsible practitioner at the time of discharge of all patients.
2. Additional diagnosis must also be recorded which may exist prior to the admission of the patient or develop after the patient's admission, but, in either case, must affect the treatment received or the length of stay.
3. This will be deemed equally as important as the actual discharge order.

K. Autopsy

1. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within five (5) days, and the complete protocol shall be made part of the record as soon as possible.

L. Authentication of Medical Records

1. All medical record entries shall be dated, timed, and authenticated promptly by the individual who is responsible for ordering, providing, or evaluating the service provided.
2. Signatures do not have to be dated if they occur in real time of the entry.
3. Electronic Signatures will be date stamped.
4. Signature stamps will not be accepted under any circumstances. Printed name stamps for legibility may be used in conjunction with physician's actual signature.
5. Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has the legal responsibility for the order or the information bearing his authentication.

M. Electronic Signature

1. A physician desiring to use electronic signature for authentication must provide a letter or signed form (Attachment A) that indicates:
 - He / She has a PIN number;
 - Is the only individual who uses the PIN number; and
 - He / She will not delegate the use of the computerized signature to another.
2. The letter shall be maintained in the physician's credentialing file in the medical staff office.
5. A copy of the request will be filed in the physician signature file in the Health Information Department.
6. Before applying an electronic signature, the physician should review the entry for completeness and accuracy, correcting or modifying it as needed.
7. Correction of errors, adding additional information after an entry has been signed electronically should be done by means of an addendum to the original entry.
6. The addendum should also be signed electronically and date/time stamped.
In no circumstances shall a single electronic signature authenticate all entries in the medical record.

N. Facsimile Signatures

1. A physician's signature transmitted via electronic facsimile is considered legal and does not require additional authentication.
2. The original document along with the faxed document should be scanned in the hospital medical record.
3. If the documents faxed are for delinquent medical records, the records will remain delinquent until the authenticated documents are returned.

O. Delinquent Medical Records

1. An automatic suspension of privileges shall be imposed for failure to complete medical records within thirty (30) days of discharge and/or visit.
2. The Medical Records Department Director shall send a written notice, including all records that are at or near delinquent status, to a practitioner indicating that his or her clinical privileges will be automatically suspended if such records are not completed. The first (1st) letter will be sent on the 14th day. Notice shall be sent by either fax, personal delivery or by certified mail, or return receipt requested. If the practitioner does not complete the medical records, a second (2nd) letter will be sent on the 21st day. If the practitioner does not complete the medical records within 30 days, a temporary suspension of all privileges shall be automatically imposed by the Administrator after consultation with the Chief of Staff with regard to whether the delinquency is based upon a medical disciplinary cause or reason.
3. Should illness or absence prevent the physician from completing his/her records consistent with the above stated timelines, the physician should notify the HIM Department. An extension will be granted not to exceed the length of the illness or absence.
4. A physician will remain in suspension until all his/her delinquent records are completed.
 - a. Scheduling of new admissions and/or surgery will not be permitted.
 - b. Physicians are allowed to provide continued care to current inpatients and patients already scheduled for surgery or to provide care in the case of an emergency.
 - c. An *“emergency”* being defined as: “a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger”.
5. In the case of a hospital based (contracted) physician, then suspension of privileges and financial compensation withheld will occur until records are completed.
6. Failure to complete the medical records which caused suspension, after three (3) months from the date of such suspension, shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff. Reapplication to the Medical Staff can be made following completion of all incomplete records. The application process shall proceed in the same fashion as any new application to the Medical Staff.

P. Medical Records Access

1. The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Medical Staff and the Hospital.
2. Subject to applicable laws, Access to medical records for all patients shall be afforded to members of the medical staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients.

3. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
4. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner whether the patient is attended by the same practitioner or by another.

Q. Confidentiality and Security of Records

1. The confidentiality of medical records shall be maintained as required by state and federal law.
2. Written consent of the patient is required to release medical information to persons not otherwise authorized to receive this information in accordance with federal, state and local statutes and regulations regarding the release of information.
3. Original records may be removed from the hospital's custody and control only in accordance with a court order, subpoena, or statute.
4. Attending practitioners shall be notified of any record that has been requested by a court order, subpoena or statute.
5. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period of time to be determined by the Medical Executive Committee.

R. Corrections

1. Electronically signed entries cannot be deleted or altered.
2. If errors are found in the electronic file:
 - Correction will be done by means of an addendum to the original entry.
 - The addendum must also be signed electronically.

S. Abbreviations, Acronyms, and Symbols

1. Only approved abbreviations, acronyms, and symbols shall be used in documenting in the medical record
2. The use of abbreviations is limited and only standard abbreviations are to be considered when documenting in the medical record.

T. Retirement of Records

1. An incomplete record will not ordinarily be filed if the responsible practitioner is still a member of the medical staff or holds clinical privileges in the hospital.
2. No medical staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him.
3. Any practitioner who is removed from the medical staff per the bylaws for delinquent records or who resigns from the medical staff without adequately completing all medical records will not be allowed to

reapply for staff membership until such records are satisfactorily completed.

IV. ORDERS

1. All patient orders shall be documented in the medical record.
2. Practitioner orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly. The use of "renew," "repeat," "resume", or "continue" orders is not acceptable. Orders must be specific.
3. All orders will be authenticated by the author (member of medical staff). Orders transcribed incorrectly will be corrected upon discovery.
4. Clinical staff in accordance with their scope of practice may accept written, verbal, and telephone orders from a physician. Verbal orders are discouraged.
5. The person accepting the verbal order must write the order and read said order back to the physician to verify the accuracy of the order. The authorized individual shall document the verified verbal order, indicating the read back verification.
5. Certain categories of verbal orders therapeutic and diagnostic may present a potential hazard to patients and are considered high risk. These high risk orders may be accepted by designated personnel and must be signed within 48 hours. Orders which fall into this high risk category include:
 - Orders for "Do Not Resuscitate" (*can only be accepted by Registered Nurse*)
 - Orders concerning the use of restraints
 - Orders to verify patient's home medications that are to be continued in the hospital (that must be individually listed).
7. Approved staff members when functioning within their sphere of competence may accept and transcribe verbal therapeutic and diagnostic orders related to their area of practice. The staff members include:
 - Nursing
Registered Nurse, R.N.
Licensed Vocational Nurse, L.V.N.
Registered Nurse Practitioner
 - Pharmacy
Pharmacist, R.Ph
 - Radiology
Registered Technologist, A.R.R.T.
 - Laboratory
Medical Technologist, M.T.
 - Physical Therapy
Licensed Physical Therapist, P.T.
 - Dietary
Registered Dietitian, R.D.
8. Verbal orders will be accepted only from authorized practitioners.
9. All routine and standing orders shall be signed by the responsible practitioner as soon as possible within 24 hours.
10. Unspecified range or variable orders are discouraged. Range orders received will be managed by pharmacy according to approved policies and procedures.

V. DRUGS AND MEDICATIONS

1. All drugs and medications administered to patients shall have been approved by the Food and Drug Administration. The only exceptions are those drugs administered under an approved protocol for investigational or experimental drug use which has been approved by an Institutional Review Board/Committee (IRB) that is acceptable to the Medical Executive Committee. When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically not defined as a drug or medication, administration of these substances will also be in accordance with an established protocol that has been approved by the medical staff through its designated mechanism. Proprietary remedies should be avoided, and if an attending practitioner orders one for a patient, the pharmacy shall obtain consult with the prescribing physician to determine medication therapy regimen.
2. Investigational or experimental drugs shall be used only under the direct supervision of the principal investigator who shall be a physician member of the medical staff and who is responsible for securing the necessary consents. The investigator shall provide to the hospital administrator or governing body evidence of adequate liability insurance.
3. The protocol for use of an investigational or experimental drug shall be submitted to the Institutional Review Board/Committee which after its evaluation will make its recommendation to the medical staff executive committee. The latter recommendation shall be given strong consideration by the governing body, which has final approval/disapproval authority. However, consistent with applicable state and federal law, the governing body cannot unilaterally approve the use of an investigational drug or device which has not received approval from the Institutional Review Board/ Committee.
4. When nurses are required to administer an investigational drug, they shall be provided access to basic information concerning the drug, including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known.
5. When a patient is admitted while on an investigational drug outside of the hospital, the medication may be continued as follows:
 - A copy of the patient's informed consent must be approved.
 - A copy of the protocol must be submitted to the Pharmacy.
 - The medication must be controlled by the Pharmacy.
 - Medication will be delivered to the Pharmacy and not left with patient or on the Nursing unit.
 - All unused drugs must be returned to the investigator / patient.

The attending physician must be a member of Harris Methodist Southlake Center for Diagnostics & Surgery medical staff but the principal investigator need not be a member of the medical staff. The attending physician must provide the pharmacy a photocopy of the patient's informed consent, which will be placed in the chart, and a copy of the protocol to file in the Pharmacy.

6. The pharmacy shall store any investigational drugs used in the hospital and be responsible for labeling and dispensing in accordance with the physician investigator's written orders.
7. Self administration medication by patients shall not be permitted.

8. If ordered by their physician, patients are encouraged to bring their own medications for use in the hospital.
9. Drugs brought into the hospital by patients may be administered by the nursing staff after the drugs have been identified by the hospital pharmacist, the pharmacy technician, or the patient's nurse; there is a written order from the responsible practitioner to administer the drugs, the medication is labeled, and the drug is not outdated.
10. Under no circumstances will the hospital pharmacy re-label medications obtained from other sources or brought from home.
11. For each medication, the administration times or the interval between doses must be clearly stated in the order.
12. The use of "prn" and "on call" in a medication order must be qualified.
13. All preprinted / standing and routine orders (particularly those involving medications) shall be initially evaluated, and, if approved, shall be evaluated periodically thereafter by the Departmental / Pharmacy and Therapeutic Committee and / or the Medical Executive Committee.
14. The Pharmacy shall have the authority to select the brand within generically equivalent products. The product will be selected according to efficacy, toxicity, pharmacokinetic properties, cost and approved and certified by the FDA as being bioequivalent to brand-name products.
15. Therapeutic interchange: Medication classes can be reviewed to select the specific medications with similar efficacy to be used by the hospital for its patient population. When approved by the Medical Staff, these medications can be automatically substituted for the specific drug prescribed, unless the practitioner specifies by order "Do Not Substitute".
16. Drug samples shall not be distributed in the hospital. Sample drugs brought into the hospital shall be controlled through the pharmacy, particularly non-formulary drugs.
17. Practitioners shall abide by drug and medication requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these rules and regulations and applicable medical staff and hospital policies. In particular, reference is made to the "Surgical Care," "Special Care Units," "Orders," sections of these rules and regulations.
18. When, in the opinion of the nursing staff or the pharmacist, a drug dosage ordered represents a potential hazard (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition) to the patient, and the prescribing practitioner disagrees, the chairman of the department/service to which the practitioner is assigned or the president of staff shall be consulted, and if he also agrees that the administration of the drug as ordered is potentially hazardous, the attending practitioner may be required to administer the drug personally and submit a written prescription to the pharmacy separate from that of the order sheet.

19. When medications are prescribed for a patient at time of discharge, the patient will be informed in writing of potential significant adverse drug-food interaction(s). This may be done by the responsible practitioner, a pharmacist or the discharging nurse. Since the discharging nurse is usually involved, the responsible physician must indicate to the nurse the discharge medications being prescribed. The provider's indication that the patient received and understood the information should be documented in the patient's medical record along with the patient's signed acknowledgment of receipt of the information.
20. A patients' current medications, upon entry to facility, will be obtained and documented. This list will be compared to the medications prescribed during hospital stay and will be communicated to the next provider of service when the patient is transferred to another setting, service, practitioner or level of care within or outside the organization. Upon discharge the patient will be informed in writing of his / her medications that have been reconciled throughout his / her stay.
21. The Medical Staff Executive Committee may restrict the use of a specific drug or class of drugs, either entirely or for use only in stated conditions or for use only on the consent of the Medical Executive Committee.
22. Emergency drug carts / trays or emergency drug storage areas shall be checked by appropriate individuals at least once per shift (while area is open for clinical care), and after each use to assure that all items are available and in usable condition. In addition there must be a system that assures the continued integrity of the cart / tray or emergency drug storage area contents between periods of use.

VI. CONSULTATIONS

1. The attending practitioner is responsible for requesting consultation when indicated and for calling a qualified consultant. The attending practitioner will provide written authorization to permit another practitioner to attend or examine the patient except when a bona fide emergency precludes this being done.
2. Any qualified practitioner with clinical privileges in this hospital may be called by the practitioner responsible for the patient to provide consultation within the consultant's area of expertise.
3. When the required consultative expertise is not available through the existing medical staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by granting temporary privileges to a qualified practitioner who is not currently a staff member as provided in the medical staff bylaws.
4. Consults should be obtained when specific areas of expertise are needed to properly take care of the patient. If the attending physician does not have the credentials to manage the circumstance, then a consult would be required.
6. Forms for requesting radiology and pathology services shall be filled out adequately, indicating the reason for the request and relevant clinical information.

VII. GENERAL REQUIREMENTS

1. Written consent of the patient is required for release of medical information to individuals not otherwise authorized to receive this information.
2. In addition to a general consent obtained by the hospital at the time of the patient's admission, specific consent must be obtained as required by law prior to diagnostic or therapeutic interventions. The attending and/or treating practitioner is responsible for documenting in the medical record the information provided to the patient relative to the intervention anticipated. Exceptions to obtaining the patient's timely consent are limited to emergency and other situations defined in the hospital's informed consent policy. All regulatory requirements relating to disclosure shall be followed. Both the patient and responsible practitioner will sign the consent form prior to diagnostic and therapeutic intervention to indicate the practitioner has personally provided specific information, including the risk, benefits and alternatives of the intervention, on which the patient has based his consent.
3. In the event of a patient death in the hospital, the deceased shall be pronounced dead by a physician. The body shall not be released until a death note is completed and placed in the medical record of the deceased.
4. All medical staff members shall report questionable deaths and secure meaningful autopsies whenever possible. Autopsies shall be performed only on appropriate written consent and in accordance with state law.

- A. A medical staff member is required to report a death to the medical examiner in the following circumstances:

When cause of death is questionable: A questionable cause of death includes, but is not limited to, the following:

- 1) Cases in which the deceased is dead on arrival (DOA).
- 2) Cases in which an individual expires within 24 hours following admission to the emergency room or ward.
- 3) When death is, or is suspected to be, from accidental, suicidal or homicidal causes, no matter how long the person has been hospitalized or has survived the injuries. The time span may run for minutes to years.
- 4) Cases of anesthetic deaths, including those under the initial induction and those who do not recover following anesthesia.
- 5) Deaths that occur during or immediately following any diagnostic or therapeutic procedure in the hospital.
- 6) Any death where the disease process responsible is either work-related or suspicious of being aggravated or accelerated at work.
- 7) Stillbirths and neonatal deaths when maternal injury has occurred or is suspected either prior to admission or during delivery.

- 8) Maternal deaths, whether during or following delivery and including any death where abortion is suspected either prior to admission or during delivery.
 - 9) The death of a person in custody or under confinement.
 - 10) Any death of a known or suspected IV drug user.
 - 11) Any death of a child younger than six (6) years old.
- B. Medical Staff members may not require an autopsy, but an autopsy may be of benefit and should be considered in the following circumstances:
- 1) The patient following surgical or other invasive procedure where a fatal outcome was felt to be highly unlikely or unexpected altogether.
 - 2) Death following drug reaction or other adverse occurrence.
 - 3) Unexpected death within 24 hours of admission.
 - 4) Unexpected outpatient or emergency death
 - 5) Family request.

All autopsies shall be performed by a pathologist, preferably the hospital pathologist or staff member unless by law the autopsy comes under the jurisdiction of the Medical Examiner/Coroner. All autopsies require the consent of the next of kin, unless ordered by the medical examiner.

5. All practitioners shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements.
6. All practitioners shall comply with requirements of the hospital's Incident / Occurrence Screening / Risk Management Program.
7. When medical record entries are authorized to be made by allied health professionals, the supervising practitioner shall countersign the entries within 48 hours.
8. All practitioners are responsible for participating in case of a declared disaster and cooperate with the disaster plan. They shall participate in disaster drills as necessary.
9. Patients will be restrained for the protection of self or others in compliance with applicable laws. When use of restraints is indicated, justification for such use and a time-limited signed order by the physician noting both start and end times will be present and used only after other alternative methods has been attempted. The order should be signed immediately, but in no case later than 12 hours. If verbal order is given for initiating a restraint, it may only be received by a Registered Nurse.

10. The ordering of any baseline admission testing (e.g., laboratory, X-ray, electro cardio-gram, etc.) shall be the responsibility of the attending practitioner on an individual patient basis.
11. Clinical laboratory tests shall be done by the hospital or in an outside (reference) laboratory recommended by the director of the pathology and medical laboratory services and approved by the medical staff. Practitioners who have such tests / examinations performed by laboratory sources other than these may enter the results in the history or progress note section of the medical record, but the report itself shall not be considered the official hospital medical record report.
12. The radiology department / service shall provide authenticated reports for all radiologic examinations performed in the hospital and, when requested, for review of examinations performed outside the hospital. In either case, this will provide the official report for the medical record. Otherwise, the attending practitioner may record his own interpretation in the history or progress note section of the medical record. When special cardiovascular radiologic procedures can be properly interpreted only with the findings and observations of the authorized practitioner (e.g., cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.
13. Practitioners requesting diagnostic examinations by the pathologist or radiologist should provide in the written request all relevant information available so as to assist in the determination of an accurate diagnosis/impression and proper use of resources.
 - a. Printed instruction sheets or patient care brochures (from clinical departments/ specialties, patient care units, or individual practitioners) provided to patients and/or families either in the hospital or at the time of discharge shall be approved for clinical relevance and patient safety by the medical staff through its designated mechanism. Generally such sheets or brochures should not be used by the practitioner as the sole source of information for purposes of obtaining informed consent.
14. Blood that has been cross matched shall be held for 48 hours at which time it shall be cancelled unless reordered. Prior to release, the ordering practitioner shall be notified. For cases in which cross matched blood is frequently ordered but not used, the use of type and screen system should be used instead of cross matching.
15. Oxygen and respiratory therapy shall be administered in accordance with the responsible practitioner's orders. In cases where the duration of treatment is not specified or is stated indefinitely, the treatment shall be discontinued unless new orders are written; however, prior to discontinuing the treatment, the nurse shall notify the responsible practitioner and confirm that the treatment should be discontinued.
16. The Infection Control Department, through its chairman or physician members, has the authority to institute any appropriate control measures or studies when it is reasonably believed that a danger to patients, visitors, or personnel exists. This includes placing a patient under isolation precautions even though the attending practitioner may not believe such is necessary.
17. Radiographs and pathology slides are the property of the hospital and may be lent to other hospitals, practitioners, or research institutions for valid reasons and only with the written permission of the patient in accordance with the policies, rules and regulations of the radiology and pathology department, the chairman of the appropriate department/service involved, and the hospital administrator.

18. All inpatients shall be visited by their attending practitioner or designee with appropriate privileges at least once daily and this shall be documented in the medical record. If an absence of more than one day is contemplated, the attending practitioner shall arrange for another qualified member of the medical staff to attend the patient, and the nursing staff shall be notified of the name of the practitioner who will be responsible in the interim.
19. Services provided will be provided by all members of the medical staff in a non-discriminatory manner without regard to age, sex, race, color, national origin, handicapping condition, or disability.

VIII. EMERGENCY SERVICES

1. The emergency medical record shall be part of the patient's hospital medical record.
2. Each emergency medical record shall be signed by the practitioner in attendance that is responsible for its accuracy.
3. There shall be a triage system to identify patients requiring urgent and emergent care are identified and cared for expeditiously.
4. The disposition of each patient shall be a physician responsibility.
5. The emergency room shall not be used for routine outpatient visits.
6. The established list of procedures permitted to be performed in the emergency room shall not be exceeded except in a bona fide emergency.
7. Procedures requiring general or major regional anesthesia shall not be performed in the emergency room, but must be performed in the surgical suite.
8. In an emergency case in which it appears that a patient requires admission to a hospital, the practitioner shall, make the appropriate transfer arrangements.
9. Attempts to limit the ER for observation status shall be limited to the shortest time possible until the decision to admit, transfer, or discharge is made.
10. Patients and/or responsible others, on leaving the emergency room following evaluation and/or treatment, shall be given written follow-up instructions, to be signed by the patient or responsible other, that he has received and understands the instructions and by the responsible practitioner or registered nurse that the patient or the responsible other has received and acknowledges that the patient understands. Any language barrier will be compensated for through use of an interpreter, interpretation line, by instructions written in the patient's language, or by another acceptable system and this will be noted on the instruction sheet.
11. The emergency room physician shall render his interpretation of X-rays in writing, and a copy of this report will be made available to the radiologist. In cases in which the radiologist's interpretation of an X ray differs from that initially made by the emergency physician, a copy of the radiologist's report shall be

made available and brought to the attention of the emergency physician and the patient's private practitioner, and the patient shall be informed of the final reading.

12. In addition to the clinical information related to evaluation, treatment, and disposition of the patient, the emergency medical record shall include: the time of the patient's arrival, the means of arrival and by whom transported, any available details of the emergency care rendered to the patient prior to arrival at the hospital, whether (and, if relevant, when and for what) the patient visited the emergency room previously, acknowledgment of any ordered test results, the condition on discharge, and any instructions given to the patient on discharge.
13. When a transportable patient requires medical staff consultation/treatment not available, the patient will be transferred to an appropriate facility as soon as possible, subject to compliance with the hospital's transfer protocol, regulatory requirements, and subject to having first obtained acceptance by that facility through a physician or other qualified health care provider.

IX. SURGICAL CARE

1. All requirements in the "Medical Records" section of these rules and regulations shall apply in the care of surgical patients, particularly with reference to the history and physical examination, the completion of operative reports, and all anesthesia-related requirements. The requirements for informed consent also apply.
2. The responsible practitioner shall record and authenticate a preoperative diagnosis prior to surgery.
3. All required or ordered test reports/results (laboratory, X ray, ECG, etc.) shall be recorded in the medical record prior to the performance of any elective surgical procedure.
4. Ordinarily all specimens removed at surgery shall be sent to the hospital pathologist for evaluation and diagnosis except for authorized exempt specimen (see attachment B) or any authorized specimen exemptions, there must be another suitable means of verification of the removal (e.g., X ray, visual inspection of residual status, etc.); a witnessed statement does not suffice.
5. Discharge of patients from the post anesthesia recovery area shall be based on a physician decision. When there is no written discharge order or authenticated verbal order by a physician to release the patient, physician approved discharge criteria is used
6. There shall be a systematic review and evaluation by the patient safety committee or the department of surgery or medical executive committee of all patients who require hospitalization following ambulatory same-day surgery.
7. Ambulatory same-day surgical procedures are limited to only those surgical procedures approved by the medical staff and administration.
7. Ambulatory same-day surgery shall be included in surgical case evaluations performed by the department of surgery and / or medical executive committee.

8. Patients undergoing ambulatory same-day surgery shall ordinarily fall either into American Society of Anesthesiologist Class I, II or medically stable as determined by the surgeon or anesthesiologist, Class III. ASA classification of IV will be evaluated on a case by case basis.
9. Practitioners performing surgical procedures shall report any post discharge infections to the hospital's infection control surveillance individual.
11. Surgeons must be in the operating room and ready to begin surgery at the time scheduled. In the event that the surgeon is not available at the scheduled time, one (1) courtesy phone call will be made to the surgeon. After a second fifteen (15) minutes expires, the case will be bumped and rescheduled. Only for justifiable reasons, will the operating room be held longer than 30 minutes, after the time the case was scheduled.
12. Surgery may be scheduled from 7:30 a.m. to 4:00 p.m. on weekdays exclusive of holidays recognized by the hospital. Cases should be scheduled to complete by 6:00 p.m. Scheduling is done through centralized scheduling office. After hours, holidays, and weekends, scheduling is done through the nursing house supervisor.
13. Patients shall be moved from the surgical suite and to the recovery post anesthesia recovery area by a licensed nurse. As needed, an anesthetist shall accompany the patient.
14. Surgical site verification is performed prior to the surgical procedure according to approved policy and procedure.
15. Prior to the start of any surgical or invasive procedure, the surgeon and surgical team will conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active not passive communication techniques.
16. Physicians and other practitioners shall abide by the OR/hospital rule on use of appropriate attire to include surgical clothes, surgical mask, surgical cap and shoe covers. Surgical mask are to be worn over the nose and mouth and changed at least between each case.
17. Practitioners called to consult in the operating suite shall comply with the OR/hospital dress code.
18. If at the end of a surgical procedure, the sponge, sharps, or instrument count is incorrect, the patient must be X-rayed and the film read prior to moving the patient out of the surgical suite, unless the patient's condition dictates otherwise.
19. All patients receiving general, spinal or other major regional anesthesia shall go to the post anesthesia care unit. Patients receiving only local anesthesia may go to the post anesthesia care unit at the request of the responsible surgeon. When the post anesthesia care unit is closed, the same degree of care shall be provided regardless of where the post anesthesia recovery is carried out.
20. The responsible anesthesiologist shall be in constant attendance during the entire procedure. Following the procedure, the anesthesiologist or qualified designee shall remain with the patient as long as required by the patient's condition relative to anesthesia status, and until responsibility for proper patient care has been assumed by another qualified individual.

21. The "surgeon of record" and the "supervising anesthesiologist" cannot be one in the same when General Anesthesia is given.
22. The primary surgeon must remain available to provide continuous care to each of his hospitalized patients. Availability is defined by response time, is based on individual patient conditions and prudent medical judgment reflecting current acceptable standards of care; but in no case will exceed thirty (30) minutes response time. Should a surgeon not be able to provide such care, he shall arrange for and specify in the Physician's Orders of the medical record, a member of the medical staff with appropriate privileges who will be able to attend to his patient. In case of failure to name such a practitioner the president of the medical staff or the hospital chief executive officer shall have the authority to call any qualified member of the medical staff should he consider it necessary. Failure of the medical staff member to meet this requirement shall be reported to medical executive committee for any action deemed appropriate.

APPROVALS:

These Rules and Regulations are adopted by the Medical Staff

Michael Pettibon, MD President of Medical Staff	July 11, 2007 Date
O. David Taunton, MD Chief of Staff	June 10, 2009 Date

These Rules and Regulations are approved by the Governing Body

Mary Brian, MD Chairman of the Governing Body	July 18, 2007 Date
David Rothbart, MD Chairman of the Governing Body	July 1, 2009 Date

Attachment B - **Authorized Exempt Specimen List**

Attachment C - **List of Governing Body Approved Categories for Allied Health Providers**

ATTACHMENT B

AUTHORIZED EXEMPT SPECIMEN LIST

1. Orthopedic Appliances
2. Foreign Bodies
3. Amputations of Traumatically Injured Members
4. Foreskin
5. Normal Placentas
6. Teeth, Provided the Anatomic Name or Anatomic Number of Each Tooth or Fragment of Each Tooth, is Recorded in the Medical Record.
7. Toenails / fingernails
8. Portion of Rib Removed to Enhance Operative Area
9. Cataracts
10. Portion of the Iris Removed During Iridectomy
11. Normal Cartilage (Turbinates are not exempt), Bone, or Skin Removed during Any Open Reduction / Wiring of Facial Fractures, or Creation of Nasal Antral Window.
12. Pacemakers
13. Port-a- Caths

ATTACHMENT C

***LIST OF GOVERNING BODY APPROVED CATEGORIES FOR
ALLIED HEALTH PROVIDERS***

Certified Registered Nurse Anesthetist
Certified Surgical Technician (CST)
Certified Surgical First Assistant (CSFA)

Physician Assistant – Certified (PA-C)

Registered Nurse- (Physician Assistant)
Registered Nurse First Assistant (RNFA)
Registered Nurse Practitioner (RNP)
Surgical Technician (ST)

APPROVED 12/05/2007:

H. ANESTHESIA: Number 3; addition of ASA level 4

H. ANESTHESIA: Number 10; addition of CRNA

IV. ORDERS: Number 7; addition of Registered Nurse Practitioner

IX. SURGICAL CARE: Number 9; addition of Anesthesiologist Class IV.

ATTACHMENT C: List of Governing Body Approved Categories for Allied Health Providers; Addition of Registered Nurse Practitioner

APPROVED 04/16/2008:

H. ANESTHESIA: Number 9; addition of 'requiring intubation'

APPROVED 02/18/2009:

VII. GENERAL REQUIREMENTS: Number 18; addition of 'twenty-four hours (24)' with deletion of 'day'.

APPROVED 07/01/2009:

Deletion of Attachment A: Computer Key Signature Authentication

III. MEDICAL RECORDS: A – Content of Medical Record, Number 2: addition and deletion of medical record content

III. MEDICAL RECORDS: C – Pre-operative History and Physicals: deletion of paragraph 1.

III. MEDICAL RECORDS: C – Pre-operative History and Physicals: change of verbiage to paragraph 4

III. MEDICAL RECORDS: G – Operative Reports: addition of verbiage to paragraph 2 and 3.

I. Discharge Summary: Change to paragraphs 1, 2, and 3

L. Authentication of Medical Records: change to paragraph 1

O. Delinquent Medical Records: deletion of paragraph 1

IV. Orders: change to paragraph 6 and 7

VII. General Requirements: paragraph 7 - addition/deletion of verbiage; paragraph 18 – addition/deletion of verbiage