Medical Staff Rules and Regulations

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Medical Staff Rules and Regulations

A. INTRODUCTION

These Rules and Regulations are established to govern the conduct of work of the Medical Staff of CHRISTUS® Mother Frances – *Sulphur Springs* (hereafter referred to as "the Hospital"). The Medical Executive Committee (MEC) shall report proposed rule changes to the medical staff as required by the Medical Staff Bylaws, Article XVII. Amendments, Section 17.3. Amendments so made shall be effective when approved by the governing board. 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.

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.

B. ADMISSION AND DISCHARGE OF PATIENTS

1. General

The hospital shall accept patients for care and treatment except for the following:

a. Non-emergency patient who has mental health issues whose care and conduct would present a problem regarding their own or other patient's safety, care and comfort.

b. Patients with critical burns, critical conditions which require tertiary care, patients requiring skilled nursing / long term care and rehabilitation, will be transferred in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements and procedures unless transfer of the patient is contraindicated in the judgment of the attending physician or the patient or surrogate decision maker objects to the transfer.

c. Patients in the custody of law enforcement agencies shall be hospitalized if the agency provides the appropriate personnel to remain with the patient.

2. Privileges to Admit

A patient may be admitted to the hospital only by a member of the medical staff with admitting privileges except for non-Medicare patients who may be admitted by a Certified Nurse Midwife as permitted by the state and within the midwife scope of practice.

3. Responsibility of Admitting Physician

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the diagnosis and treatment of each patient within the area of his privileges, for the prompt completeness and accuracy of the medical record, for writing orders and supplying special instructions, and for supplying the patient, the patient's family, and any referring or consulting physicians with information regarding the patient's condition and treatment. Whenever these responsibilities are transferred to

another staff member, a note to that effect shall be entered into the patient's record. The intended transfer of a patient to the care of another attending physician shall first be verbally communicated to, and requires approval from, the attending physician accepting such patient transfer.

The admitting practitioner shall be held responsible for providing thorough documentation in the medical record upon admission; such information as may be necessary to assure the protection of himself or others whenever his patients might be a source of danger from any cause whatever.

The admitting physician shall be responsible for admitting orders. For patients that are admitted through the Emergency Department, the ED physician on duty may write admitting orders in conjunction with the attending physician. The attending physician or designee (physician or AHP) must see their patients on a daily basis.

4. Reason for Admission

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

5. Emergency Admissions

A patient, who requires admission on an emergency basis but does not have a private practitioner on the hospital medical staff, will be attended by the member of the hospital medical staff designated as the physician on emergency services call. It will be the responsibility of the physician who is on call to make arrangements for the care of such patients who require admission to Services other than Services to which he regularly admits. Any patient admitted through Emergency Room must be seen within 24 hours by the attending physician (unless covered by ICU criteria).

6. Admissions to the Inpatient Rehab Unit

The Medical Director of Center for Acute Rehab Excellence (C.A.R.E.) inpatient rehabilitation unit shall be the admitting and attending physician for patients in the rehab unit. The Medical Director may request consultation(s) from other members of the medical staff to treat a specified medical condition. The attending physician shall examine inpatients of the C.A.R.E. Unit a minimum of three (3) times a week.

7. Temporary Assignment of Coverage

Each member of the staff will name a member of the medical staff who may be called to attend his patients in case an emergency occurs when he is temporarily unavailable. When a medical staff member plans to be out of town, patients should be assigned to another member of the medical staff. A note to this effect should be made on the physician order sheet.

Nursing service personnel or hospital personnel in charge of maintaining an on call schedule for such circumstances should be notified. No physician whose admitting privileges have been suspended shall have his patients admitted by another physician and then care for them himself.

8. Priority of Admissions

The following patient admission category priorities shall be observed:

a. Emergency Admissions
This category includes those patients who could not be reasonably cared for on an outpatient basis without substantial increased risk of mortality or increased significant morbidity and for whom an admission cannot be scheduled. Within 48 hours following an emergency admission, the attending physician shall furnish to the MEC a signed, sufficiently complete documentation of need for this admission, if requested.

b. Urgent Admissions
This category includes non-emergency patients for whom a prolonged delay of admission will increase the risk of mortality or morbidity. Urgent admissions shall be reviewed as necessary by the MEC to determine priority when all such admissions for a specific day are not possible.

c. Pre-Operative Admissions
This includes all patients already scheduled for surgery. If it is not possible to handle all such scheduled admissions, and no urgency can be declared, priority will be ascertained according to the time the surgery was posted.

d. Direct Admission
Patients admitted directly to patient care areas by practitioners.

e. Routine/Elective Admissions
Patients admitted for routine or pre-scheduled admissions, procedures, and/or treatment.

f. Transfer Admissions
Patients received from a referring facility for admit.

When a bed shortage for elective or routine cases exists, priority shall be given to members of the active medical staff, subject to the needs of the patient in each case. If there is any question concerning the admission of a patient, the Chief of the Medical Staff shall determine the necessity for, or deferment of, the admission.

9. Continued Stay Documentation
The attending practitioner is required to document the need for continued hospitalization after specific periods of stay (per disease categories as defined locally) as identified by the appropriate Service committee of this hospital, and approved by the medical staff. This documentation must contain:

a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

b. The estimated period of time the patient will need to remain in the hospital.

c. Plans for post-hospital care.

Upon request of the appropriate Service committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient, whose hospitalization exceeds defined parameters, including an estimate of the number of additional days of stay and the reason therefore. This report must be

submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the MEC for action.

10. Patient Internal Transfers

Internal transfer priorities shall be as follows:

a. Emergency Room to appropriate patient bed.

b. From Intensive/Cardiac Care Unit to general care area.

c. From Step-down to general care area.

d. From Obstetric patient care to general care area, when medically indicated.

e. From temporary placement in an inappropriate geographic area to a more appropriate area for that patient.

Except as otherwise provided in hospital policies for utilization of intensive care beds, no patient will be transferred without consulting the responsible medical staff members with the exception of a harmful or infectious patient who needs immediate relocation to protect himself or others.

11. Discharge of Patients

Patients shall be discharged upon the order of the attending practitioner or his Designee (physician or AHP). Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and an attempt be made by the charge nurse on duty or the assigned RN to get the patient to sign the hospital release form (i.e., AMA form) stating that he is leaving against medical advice.

12. Discharge Planning

Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge planning shall include, but need not be limited to, the following:

a. Appropriate referral and transfer plans.

b. Methods to facilitate the provision of follow-up care.

c. Information to be given to the patient or his family or other persons involved in caring for the patient on matters such as the patient's condition; his health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complication.

13. External Transfer of a Patient

External transfers shall adhere to the Patient Transfer and Transfer to CHRISTUS® Mother Frances – *Sulphur Springs* policies (see Institutional Manual) in accordance with COBRA/OBRA. A patient shall not be transferred to another medical care facility unless there is an accepting physician at the other medical facility and prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

14. **Death of a Patient**
    In the event of a hospital death, the deceased shall be pronounced dead within a reasonable time by the attending practitioner or his designee or by a registered nurse acting within the guidelines of the nursing policy pertaining thereto. Policies with respect to release of the deceased shall conform to local law. The attending physician will be responsible for signing death certificates.

15. **Autopsy**
    It shall be the duty of all staff members to secure consent for meaningful autopsies whenever possible. (See Autopsy Criteria of the Institutional Manual). An autopsy may be performed only with a written consent, signed in accordance with state law. An exception to this rule will be those in which the Justice of the Peace will determine disposition of body for autopsy. Provisional anatomic diagnosis shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the record within 3 months. Physicians should document request for autopsy or contraindications.

C. PATIENT CARE AND ON CALL COVERAGE

1. **Continuous Patient Care**
   Each Medical Staff member shall provide for the continuous care of his or her own and assigned patients in the hospital, either by himself or by other appropriate members by prior mutually acceptable arrangements. In case of failure to provide for continuous care, the Chief or his designee of the Service concerned, and, if unavailable, then the Chief of the Medical Staff or his designee should be contacted. The Chief of the Medical Staff or Chief of the Service concerned, or their designee shall have the authority to call any member to attend the patient.

2. **Emergency Department On Call Obligations**
   Each Medical Staff member shall, as a condition of appointment and reappointment, agree to participate in the Hospital's Emergency Department call coverage programs for addressing patients requiring stabilizing care and treatment for emergency medical conditions and patients requiring admission to the Hospital for inpatient medical treatment.

On call responsibilities, the policy for establishing a coverage roster and schedule, and related Emergency Department admissions requirements are set forth in Hospital policy _________. D. GENERAL CONDUCT OF CARE

1. **Consent for Treatment**
   Consent forms will be obtained for all invasive procedures in accordance with the Texas Medical Disclosure Panel guidelines. This specifically requires that the patient, or an individual who may legally consent for the patient, must understand the nature of the procedure or treatment, the medically acceptable alternative procedures or treatments, the substantial medical risks and hazards inherent in the proposed treatment and the significant medical risks associated with refusal. It shall be the responsibility of the practitioner performing the procedure to provide the patient or representative with this information.

2. **Physician Orders**

Physicians will follow CHRISTUS Mother Frances Hospital – Sulphur Spring's policy on orders. Blanket reinstatements of previous orders for medications are not acceptable (e.g., "resume home meds", "resume pre-op orders" are not acceptable).

Timeliness of Entries

Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time events occurred if time is pertinent to the situation

Predating and back-dating

It is both unethical and illegal to pre-date or back-date an entry. Entries must be dated for the date and time the entry is made.

When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the health record. Following are the guidelines for entering late documentation:

a. Identify the new entry as "late entry."
b. Enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time.
c. Identify or refer to the date and incident for which the late entry is written.
d. If the late entry is used to document an omission, validate the source of additional information as much as possible (e.g., where you obtained the information to write the late entry).
e. When using late entries, document as soon as possible. There is no time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes.

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. When making an addendum:

a. Document the current date and time.
b. Write "addendum" and state the reason for the addendum referring back to the original entry.
c. Identify any sources of information used to support the addendum.
d. When writing an addendum, complete it as soon after the original note as possible.

3. **Consultation**

Any qualified member of the medical staff with clinical privileges in this hospital can be asked for consultation within his area of expertise. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit the consulting

practitioner to attend or examine his patient, except in an emergency. The physician requesting the consultation should indicate the reason(s) for the consult, and shall initiate the consultation by practitioner-to-practitioner communication. The physician requesting the consultation should communicate to the consultant the time-frame in which the consultation should be performed.

In circumstances of grave urgency, the Chief of Staff or the appropriate Chief of Service shall at all times have the right to call in a consultant or consultants. It is the duty of medical staff, through the Credentials Committee, the appropriate Chief of Service, and the Executive Committee to make certain that members of the medical staff request consultations when needed. The attending physician will be responsible for signing death certificates.

The physician in charge is responsible for the patient's management and is privileged to vary the treatment outlined and agreed on at consultation whenever such a change is warranted. The consultant's recommendations to the attending physician should be specific as to diagnosis, therapy, expected outcome, possible complications, and how to recognize and what to do if therapy does not succeed.

Consultation is recommended in the following situations except in an emergency:

a. Procedures in which a pregnancy may be prematurely terminated.
b. An insulin dependent diabetic patient undergoing abdominal surgery must be evaluated by a physician before going to surgery.
c. When the patient is not a good risk for operation or treatment.
d. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
e. Where there is doubt as to the choice of therapeutic measures to be utilized.
f. In unusually complicated situations where specific skills of other practitioners may be needed.
g. In instances in which the patient exhibits severe psychiatric symptoms.
h. When requested by the patient or his family.

Consultation by a Pediatrician is recommended for all pediatric admissions to the ICU.

4. Dental Care

A patient admitted for dental care is the dual responsibility involving the dentist and a physician member of the medical staff.

Dental inpatient admissions or outpatients shall include a documented medical consultant physician member of the staff who shall be responsible for the medical care of the patient and assessment of the medical risks of any proposed surgical or invasive procedure. The consultant physician shall be responsible for completing a history and physical on the patient and the name of the consultant physician shall be documented in the patient's medical record. The dentist may update the history and physical as

required and is responsible for the part of the history and physical examination that deals with dentistry. Qualified oral surgeons who admit patients without medical problems may perform the history and physical examination and assess the medical risks of the proposed surgical or other invasive procedures provided the surgeon is credentialed and privileged to do so.

Securing the appropriate medical consultations and seeing that a physician follows the course of a patient while in the hospital is the responsibility of the admitting dentist.

5. **Podiatric Care**

Outpatients
Podiatric providers shall perform and dictate a focused history and physical examination for ASA Class I or II outpatient surgeries. Patients with an ASA Class III or higher will require a history and physical examination to be performed by a qualified licensed individual, acting within their scope of practice under state law or regulation, who is not required to be a member of the medical staff. The history and physical examination must be completed within 30 days of the scheduled procedure or prior to a procedure requiring anesthesia services. The podiatrist is required to provide an update to the history and physical examination to include any changes and/or specialty examination. If any medical or psychiatric problem is present at the time of service or develops during the service that is outside the scope of practice of the podiatric provider, a physician member of the medical staff must be consulted.

Inpatients
A patient admitted for podiatric care is the dual responsibility involving the podiatrist and a physician member of the medical staff or Inpatient hospitalist. Podiatric Inpatients require a history and physical examination to be performed by a qualified licensed individual, acting within their scope of practice under state law or regulation, who is a member of the medical staff and is responsible for the admission. The history and physical examination must be completed within 24 hours of admission.

6. **Control of Infections**
It is the duty of the attending practitioner to notify the hospital if a particular patient has an infection which is transmissible within the hospital. The practitioner should specify the diagnosis so that if any measures beyond Standard Precautions are required they can be implemented. If the practitioner is not available to order the isolation and if the nurses become aware of a diagnosis which requires special isolation, they may isolate the patient until they can consult with the practitioner. The nurse should notify the Infection Control Department of the name of the patient and the diagnosis. If any unusual incidence of infections, such as wound infections or urinary tract infections is suspected, the practitioner or the nurses should notify the Infection Control Department. Physicians are urged to report nosocomial infections, which are discovered after the discharge of the patient.

7. **Patient Rights**
Members of the Medical staff shall follow the Hospital's Patient Rights Policy(ies)

respecting the privacy, confidentiality and the rights of patients at all times.

8. **Restraints and Seclusion**
   Physicians will follow the Hospital's policy on restraints/seclusion. PRN restraint orders are never acceptable and will not be executed[5].

9. **Organ Procurement**
   Organ procurement shall be handled as required by and in a manner consistent with the Hospital's Organ and Tissue Donor policy and relevant state and federal laws. Practitioners from outside transplant centers, tissue banks or organ procurement centers who come to the hospital for the purpose of harvesting organs for transplant, therapy or research shall be excluded from any requirement for membership in the medical staff.

10. **Computer System**
    The Hospital uses automated information systems for transmittal of hospital orders and results, and for the maintenance and distribution of patient information. Physicians will have access to these systems. It is the physician's responsibility to use the systems in accordance with the appropriate Hospital policy and procedures.

E. MEDICAL RECORDS DOCUMENTATION

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

1. **Content**
   This record shall include identification data; complaint; personal history; family history; history of present illness; physical examinations; system review, provisional diagnosis; special reports such as consultations, clinical laboratory and radiology services, and others; medical or surgical treatment; operative reports; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note (clinical resume); and autopsy report when performed.

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

3. **<u>History and Physical Exams Content</u>**
   A complete H&P has the following components: history, physical examination, assessment and treatment plan as indicated:
   a. History includes:

      - Presenting diagnosis/condition (chief complaint/reason for the visit)
      - Description of symptoms
      - Current medications, biological, nutraceuticals
      - Any drug allergies
      - Significant past medical & surgical history
      - Review of systems
      - Psychosocial status

- Nutritional evaluation (if GI, pediatrics, or elderly)

For surgery or invasive procedure requiring moderate sedation or anesthesia:

In addition to the basic content listed above, surgical history and physical exam must include:

- Indications
- Proposed procedures
- Neonatal history (pediatric patients, if applicable)

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

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

c. Assessment

d. Treatment Plan

4. Interval H&P

An interval H&P is an addition to or updated documentation to an original H&P. If the original H&P is older than 24 hours but less than 30 days old an interval H&P is required and it must contain documentation of the changes in medical history or physical exam, or a statement indicating that no changes have occurred. Interval H&P's are only required for patients in an outpatient status.

5. History and Physical Examination

History and physical examinations shall be completed as described in and required by the Medical Staff Bylaws and as noted in Sections D.4 and D.5 above. In addition to the general guidelines for history and physicals as outlined in the Medical Staff Bylaws, for patients (observation or admitted) with emotional or behavioral disorders physicians should include at least the following elements as applicable:

a. A history of mental, emotional, behavioral and substance use problem(s), their co-occurrence and treatment.
b. Current mental, emotional, and behavioral functioning, including a mental status examination.
c. Maladaptive or problem behaviors.
d. A psychosocial assessment.

Patients being treated for alcohol and other drug dependencies have specific needs that are consistently addressed in their assessment and reassessment, regardless of the setting or Service in which the assessments take place. These areas include as applicable:

a. The patient's history of alcohol, nicotine, and other drug use, including onset, duration, intensity, patterns of use, and consequences of use.
b. The types of previous treatment and response to that treatment.
c. A history of mental, emotional, and behavioral problems, their co-occurrences with substance use problems and their treatment.
d. A history of biomedical complications associated with alcohol, nicotine or other drug use, and the patient's level of awareness of the relationships between these behavioral conditions and the patient's pattern of substance use.
e. A psychosocial assessment.

For patients admitted to the Center for Acute Rehab Excellence (C.A.R.E. Unit), the admitting physician shall record a history and physical within 24 hours of after admission. This report shall include the chief complaint; history of present illness; allergies; admitting medications; relevant medical, surgical, family, social, and functional histories (appropriate to age); review of systems; a report of relevant physical examinations; plan of treatment; estimated length of stay; and, rehab prognosis. The history and physical may be performed prior to admission, not to exceed thirty (30) days prior to admission, only if an appropriate update is done.

If the history and physical exam is completed by a designee of the admitting physician, the admitting physician must review and validate the content with a signature within 24 hours. Entries must be signed, dated and timed.

6. **History and Physical Examination Prior to Invasive Procedure**
History and physical examinations shall be completed as described in the Medical Staff Bylaws. Pre-operative history and physicals should be dictated 24 hours prior to the time of scheduled surgeries or procedures requiring anesthesia services in order to allow reasonable transcription time. 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.

A history and physical must be performed within thirty (30) days of admission. If a

history and physical is performed within 30 days of admission, an updated examination for any changes in the patient's condition must be completed and documented in the patient's medical record within twenty-four (24) hours after admission is required. If history and physical is older than thirty (30) days, a new examination and history and physical is required.

All non-MD and non-DO staff members must have a primary care H&P for patients. (NOTE: Podiatric patients with an ASA Class I or II may be admitted by podiatrists who shall perform and dictate an appropriate history and physical. Patients with an ASA Class III will require a Family Practice consultation with the assessment and dictation of the History and Physical performed by the Family Practice physician.)

7. **History and Physical for Outpatient Services**
The history and physical will minimally consist of a chief complaint, brief history, including current medications and allergies and a system-specific physical to include a respiratory and cardiac examination, diagnosis/problem list with initial plan of care.

8. **Progress Notes**
Pertinent progress notes shall be recorded at the time of observation and sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as any change of condition and results of tests and treatment. Progress notes shall be written at least daily, and shall be legible, dated, timed and signed.

Regarding patients in the C.A.R. E. Unit, pertinent progress notes shall be recorded at a minimum of three (3) times per week. Progress notes shall be legible, dated, timed and signed.

9. **Operative Notes**
For inpatients and outpatients, a brief operative/procedure progress note will be entered in the EMR shortly after the procedure or before transfer to next level of care. A brief operative or procedure note must include the following: surgeon and any assistants, post-operative diagnosis, procedure performed, estimated blood loss, and complications or indication there were none. A detailed operative report shall be written or dictated immediately and shall include patient name; ID number; date of service; type of procedure; preoperative diagnosis; name of the primary surgeon and assistants; findings; technical procedure used; specimen removed; estimated blood loss; type of anesthesia administered; any complications; any prosthetic devices; grafts, any tissues or transplants implanted; and, postoperative diagnosis. The operative report shall be made a part of the current medical record and signed as soon as practicable. If the operative report is not dictated within 24 hours, the physician will be considered delinquent and sent a warning letter. If the physician continues to be delinquent beyond 14 days from date of procedure for missing or incomplete operative note, a temporary suspension of privileges will be issued until completion; as per the Bylaws.

10. **Consultations**
Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited

statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

11. Prenatal Record used for History and Physical Exam

The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, or as soon as practical. An interval admission note updating the prenatal H&P, as specified by the interval H&P rule previously referenced, must be documented and includes pertinent additions to the history and/or any subsequent changes in the physical findings.

12. Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the medical staff. A list of approved abbreviations and the list of “do not use abbreviations” are available on the intranet at the link entitled “Medical Abbreviations”.

13. Final Diagnosis

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of the patient’s discharge. Additional diagnoses which may exist prior to the admission of the patient or develop after the patient’s admission must also be recorded. But, in either case, diagnoses must affect/reflect the treatment received or the length of stay. This will be deemed equally as important as the actual discharge order.

14. Discharge Summary

A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over 48 hours. The discharge summary must contain the following information:

a. Reason for hospitalization.

b. Care, treatment, and services provided

c. Significant findings.

d. Procedures performed and treatment rendered.

e. Patient's condition and disposition at discharge.

f. Any instructions to the patient/family or significant other.

g. Provisions for follow-up care

h. Final diagnosis.

i. Signature, dated, and timed

When individual patients are seen for minor problems or interventions, and stay less than 48 hours, a final progress note may be substituted for the discharge summary. Normal obstetrical deliveries and normal newborn infants may contain instead an extended final progress note. A final progress note includes the final diagnoses, sufficient information to justify the diagnosis and warrant the treatment, and disposition of the patient at discharge. In the event of patient death, a death summary shall be

completed. **A Discharge Summary is the responsibility of the attending physician.**

15. Death Summary

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

- Admitting date and reason for hospitalization
- Date of Death
- Final Diagnoses
- Succinct summary of significant findings, treatment provided and patient outcome
- Documentation of all procedures performed during current hospitalization and complications (if any)

16. Emergency Room Record

A medical record is maintained on every patient seeking emergency care and is incorporated into the patient's permanent record. The emergency record should include:

a. Pertinent history of the illness or injury and physical findings, including patient vital signs.

b. Diagnostic impressions.

c. Conclusion at the termination of evaluation/treatment, including final disposition of the patient's condition on discharge or transfer and any patient teaching and instructions for follow-up care.

The Emergency Department assessment should be completed by the end of the emergency practitioner’s shift in the Emergency Department. In all instances, the contents of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

17. Authentication of Records

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. Signatures do not have to be dated if they occur in real time of the entry. Electronic Signatures will be date stamped.
Signature stamps will not be accepted under any circumstances. Printed name stamps for legibility may be used in conjunction with physician’s actual signature. 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.

The attending physician shall countersign (authenticate) the history, physical examination and preoperative note when they have been recorded by a PA, NP or Medical Student. The attending physician’s countersignature shall be entered into the medical record within 24 hours.

18. Electronic Signatures

A physician desiring to use electronic signature other than the hospital system for authentication must provide a letter or signed form that indicates:

a. He has a PIN number/password.

b. Is the only individual who uses the PIN number/password.

c. He will not delegate the use of the computerized signature to another.

The letter shall be maintained in the physician's credentialing file in the medical staff office. A copy of the request will be filed in the physician signature file in the Health Information Department.

Before applying an electronic signature, the physician should review the entry for completeness and accuracy, correcting or modifying it as needed. 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.

19. Facsimile Signatures

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

20. Corrections

Corrections in written records shall be made by drawing a single line through the incorrect entry and new information written. The correction will be initialed, dated, and timed.

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

21. Confidentiality and Security of Records

The confidentiality of medical records shall be maintained as required by state and federal law. 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.

22. Ownership of the Medical Record

All records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the medical staff.

23. Access to the Medical Record for Research

Free access to all medical records of all patients shall be afforded to members of the

medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the medical staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attend such patients in the hospital.

24. Completed Medical Record

The patient's medical record must be completed within 30 days following discharge. Failure to do so will result in automatic suspension as required in Article VIII, Section 3 of the Medical Staff Bylaws.

In the event the incapacitation of a practitioner, for whatever reason, will preclude the timely completion of outstanding medical records, the Chief of Staff is empowered to appoint an active medical staff member or members to complete said records. Failure to complete such records on the part of the appointed practitioner within 5 days will subject him to the same sanctions of the Medical Staff Bylaws, Article VIII, Section 3, as though the records were originally his own. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the MEC.

F. PROFESSIONAL CONDUCT

1. Ability to Perform Duties

All applicants to the Medical staff except telemedicine only providers, will be required to submit evidence of an annual TB test **or** CXR **or** risk assessment. If a question arises regarding a physician's ability to perform his duties due to health or other reasons, the MEC may require a medical release signed by a physician who has direct knowledge of the health status of the applicant.

2. Requirements for Continuing Professional Education

Continuing medical education is encouraged and supported by the medical staff and the Hospital. The requirement for CME for the Medical Staff members shall be that of the Texas State Licensing Boards. Documentation of CME shall be maintained by the medical staff member. Affiliate Members, Dentists and Podiatrists shall complete the number of CME hours required by their State Licensing Board.

3. Disruptive Conduct

Medical staff members are expected to conduct themselves in a professional and collegial manner. Medical Staff members who engage in disruptive or unprofessional conduct may be subject to disciplinary action.

a. First occurrence – incident will be informally discussed with the specific physician and the Chief of the Medical Staff or Service Chief.

b. Second occurrence – repetitive incidents shall be discussed with the specific physician, Chief of the Medical Staff, Service Chief, and an appropriate member of Hospital administration. Written documentation of incidents and behavior should be included.

c. Third occurrence – possible recommendation to the MEC to initiate a formal

investigation *(see Medical Staff Bylaws)* and consider final corrective action. Written documentation of additional incidents and behavior should be included.

The Chief of the Medical Staff, any Service Chief, the majority of any medical staff committee, the Chief Executive Officer, or the Chairman of the Board may refer any single incident deemed severe or disruptive to the MEC for investigation and appropriate discipline.

4. **Professional Practice Evaluation and Peer Review**
The Medical Staff shall define, determine and evaluate the competency of each member of the medical staff and allied health professional. Competency includes the ability to provide care, treatment and service in accordance with the credentialing and privileging process and requirements of the Medical staff. This responsibility will be implemented by the Service Chief, credentials committee MEC, and the Chief of the Medical Staff.

5. **Medical Staff Member Notification**
It shall be the responsibility of Medical Staff Members to provide the Medical Staff Services Office a current office address and phone number and to promptly notify the Medical Staff Services Office of any changes. Notification and/or correspondence to the address on record in the Medical Staff Services Office for the Member shall be considered notice to the Member**.**

G. FUNCTION AND ORGANIZATION OF SERVICES

1. **Organization of Services**
The Medical Staff shall be organized in the following Services:

   a. Surgical Service
   b. Anesthesia
   c. Pediatric
   d. Perinatal
   e. Family Practice/Medical Service
   f. Emergency/Trauma

Each Service shall have a Chief who shall be elected and have the qualifications, duties, and responsibilities as set out in Article XI of the Medical Staff Bylaws.

The services may convene as ad hoc committees of the MEC for the purpose of considering topics of import to the hospital units represented by the services (e.g., review policies, peer review[12], discuss quality/process improvement issues). The service-related ad hoc committees are as follows:

   a. Operative and Invasive Committee (includes Interventional/Procedural Radiology)
   b. Family Practice/Intensive Care/Medicine/Emergency Medicine/Rehab (includes Clinical/Diagnostic Radiology[14] and Pathology); Trauma serves as

a sub-committee

c. Perinatal/Pediatrics

2. Future Services

When deemed appropriate, the Executive Committee and the Board, by their joint action, may create, eliminate, subdivide, or combine Services.

To assure that new services and/or procedures can be provided appropriately, effectively and are financially feasible for the Hospital District, all clinical areas should follow the "Physician/Hospital/Service-Procedure Alignment" policy. However, in cases of required expediency, a new or unusual procedure, or a procedure for which a practitioner's privileges are not certain, the following steps should be followed:

a. Contact the Chief of Service, Chief of Staff or Chief Medical Officer AND the Chief Nursing Officer for review for appropriateness of the procedure.

b. The clinical Chiefs will refer the matter with their recommendations to the Chief Financial Officer for further evaluation.

3. Assignments to Services

Each member of the staff shall be assigned membership in one primary Service, but may be granted membership and/or clinical privileges or specified services in another Service area. The exercise of clinical privileges or the performance of specified services within any Service area shall be subject to the rules and regulations of that Service and the authority of the Service Chief. A staff member, meeting the qualifications of an Active staff member, with privileges in more than one Service shall vote only in the Service in which he holds primary privileges, but shall be entitled to attend meetings of any Service in which he holds privileges.

4. Functions of Services

The primary responsibility delegated to each Service is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Service.

To carry out this responsibility, each Service shall:

a. Participate in the quality and utilization programs for the purpose of reviewing and evaluating the quality of care within the Service.

b. Establish guidelines for the granting of clinical privileges within the Service and submit the recommendations required regarding the specific privileges each staff member or applicant may exercise.

c. Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state of the art and to findings of review, evaluation, and monitoring activities.

d. Monitor, on a continuing and concurrent basis, adherence to:

(1) Staff and hospital policies and procedures.

(2) Requirements for alternate coverage and for consultations.

(3) Sound principles of clinical practice.

(4) Programs designed to promote patient and employee safety.

e. Coordinate the patient care provided by the Service's members with nursing and ancillary patient care services and with administrative support services.

f. Submit written reports to the Executive Committee concerning:

(1) Findings of the Service's review, evaluation, and monitoring activities, actions taken thereon, and the results of such action.

(2) Recommendations for maintaining and improving the quality of care provided in the Service and the hospital.

(3) Such other matters as may be requested from time-to-time by the Executive Committee.

5. Modifications in Clinical Organization Unit

Upon recommendation of the Chief of Staff and the Executive Committee, the Board may create, eliminate, subdivide, or combine Services, or any other clinical organization units at the hospital.

6. Medical Quality Improvement

The responsibility of the Medical Staff in regards to quality improvement is outlined in the Hospital Quality Improvement Plan. Each Service shall be responsible for medical quality improvement and shall monitor staff functions within its Service.

7. Committees of the Medical Staff

a. Credentials Committee

The MEC shall act as the Credentials Committee. The Chief of Staff, at his discretion, may appoint other members on an ad hoc basis. The duties of the Credentials Committee shall be to:

(1) Review and evaluate the qualifications of each practitioner applying for reappointment and the granting or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate Service(s).

(2) Submit required reports and information to the Board on the qualifications of each practitioner applying for reappointment or particular clinical privileges including recommendations with respect to reappointment, membership category, Service affiliation, clinical privileges, and special conditions.

(3) Evaluate, review, and make recommendations on matters regarding the qualifications, conduct, professional character, or competence of any applicant or medical staff member.

b. Bylaws Committee

There will be a Bylaws committee composed of the MEC Members, the Director of Risk/Compliance/Quality, the Director of Medical Staff and representation from Administration. The Vice Chief of Staff or appointed

representative shall be the chairman of the Bylaws Committee.

c. Death Review Committee
The appropriate Service committee shall review any death failing screening criteria. Special consideration shall be given to the review of patients with infections, complications, possible errors in diagnosis and treatment and unexplained or unexpected deaths.

H. ALLIED HEALTH PROFESSIONAL SERVICES

1. Qualifications
The Allied Health Professional Staff shall consist of certain non-physician health care professionals who are designated by the Board of Directors as members of a profession appropriate for recognition as Allied Health Professional Staff. These individuals shall be licensed to practice a specific health related discipline by the State of Texas, and when applicable, shall be registered or certified by a nationally recognized certification agency.

2. Privileges
Each category of the Allied Health Profession shall be assigned to the Service in which lies the major part of their activity. The specific qualifications and privileges for each category of Allied Health Professional shall be recommended by the supervising Service to the MEC. However, the Allied Health Profession disciplines which are to be recognized by the professional staff are to be determined by the Board of Directors in its exclusive discretion. No person shall be entitled to Privileges to practice as an Allied Health Profession in the Hospital simply by virtue of the fact that he practices in the community, is a member of a professional organization in his field, is a graduate of a training program or school, or is licensed in the state of Texas. No individual shall be denied clinical privileges on the basis of gender, race, creed, religion, color, or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

Each Service Chief shall prepare a proposed delineation of privileges for each class of Allied Health Professional that will practice in such Service and shall develop such other criteria regarding the practice of each class of Allied Health Professional within the Service, and shall forward the foregoing to the MEC for review and recommendation.

3. Supervision
All allied health professionals will be under the supervision of a physician who is an active medical staff member and who will be responsible for the performance of each of these individuals.

4. Admitting
With the exception of a Nurse Midwife the Allied Health Professional may not admit or discharge patients. The Nurse Midwife may admit patients only within the scope of his/her privileges.

5. **Delegation to Certified Registered Nurse Anesthetists**
   A physician may delegate to a Certified Registered Nurse Anesthetist (CRNA) the ordering of drugs and devices necessary for a CRNA to administer an anesthetic or an anesthesia related service ordered by the physician. This delegation will allow the CRNA to sign a prescription or to place an order for a drug directly with a hospital pharmacy without having to have a physician's co-signature on the prescription or order. The physician's order for anesthesia or anesthesia-related services does not have to be drug specific, dose-specific or administration-technique-specific. Pursuant to the order, the nurse anesthetist may select, obtain, and administer those drugs and apply the appropriate medical devices necessary to accomplish the order and maintain the patient within a sound physiological status. This paragraph shall be liberally construed to permit the full use of safe and effective medication orders to utilize the skills and services of certified registered nurse anesthetists.

   A physician shall not be liable for the act or acts of a CRNA solely on the basis of having signed an order, a standing medical order, a standing delegation order, or protocols authorizing a CRNA (or physician's assistant or advanced nurse practitioner) to perform the act or acts of administering, providing, carrying out, or signing a prescription drug order unless the physician has reason to believe the CRNA (or physician's assistant or advanced nurse practitioner) lacked the competency to perform the act or acts.

6. **Reappointment**
   All Allied Health Care Practitioners will be reviewed for reappointment every two years and shall request for renewal of clinical privileges following the same reappointment process as for physicians.

7. **Contracted Services**
   If a hospital extends clinical privileges to an advanced practice nurse or physician's assistant conditioned on the advanced practice nurse or physician's assistant having a sponsoring or collaborating relationship with a physician and that relationship ceases to exist, the advanced practice nurse or physician's assistant and the physician shall provide written notification to the hospital that the relationship no longer exists. Once the hospital receives such notice from an advanced practice nurse or physician's assistant and the physician, the hospital shall be deemed to have met its obligations under this section by notifying the advanced practice nurse or physician's assistant in writing that the advanced practice nurse's or physician's assistant's clinical privileges no longer exist at that hospital.

I. MEDICAL AND PHYSICIAN'S ASSISTANT STUDENTS

Medical students and physician's assistant students will be under the direct supervision of the designated preceptors in the care of patients in the ambulatory, emergency room or hospital setting. Physician preceptors shall be members of the Active Medical Staff in good standing with relevant clinical privileges approved and on file in the hospital. The Chief of Service of the preceptor shall approve each student for each procedure.

Medical and physician's assistant students will not evaluate, treat and/or discharge a patient from any setting without the direct involvement of the designated preceptors.

Furthermore, no medical staff member shall leave patients under the care of a medical or physician’s assistant student as primary coverage.

A medical or physician’s assistant student may enter orders, progress notes and history and physicals on the medical record; however, these must be countersigned by the physician preceptor within 24 hours. Orders written by the student must be countersigned by the physician preceptor prior to being carried out. In some instances, telephone authorization can be used to initiate orders written by the student, but in all cases orders must then be countersigned.
Students shall not perform any invasive, therapeutic or diagnostic procedures (excluding venipuncture and similar procedures) without the designated preceptor or associate preceptor being present. A list of acceptable procedures will be kept on file in the Medical Staff Office, and prior to performance of any procedure.

The student must identify himself to each patient as being a student prior to any examination or treatment of the patient. The student will not prescribe, or cause to be prescribed or dispensed, medications without the co-signature of a physician.

J. HOSPITAL SERVICES

1. Surgical Service Rules and Regulations

Reservations for surgical procedures are made on first come first serve basis, except as specified by policies approved by the appropriate Service committee. The following information is required for scheduling a procedure:

a. Patient's name.
b. Age.
c. Diagnosis (Day surgery or Admitting Diagnosis).
d. Procedure.
e. Physician and assistant.
f. Type of anesthesia.
g. Time surgery scheduled.
h. Area coming from (unit or floor).

Changes in the surgery schedule may be made at any time but will be subject to cases that have already been scheduled. Emergency operations are performed at any time and when life threatening in nature, take priority over scheduled surgery.

Prior to Anesthesia and commencement of an operation, confirmation by surgical staff of the following documentation is required:

a. Identification of patient.
b. Pre-Operative evaluation and documentation.
c. Medical record content, including diagnosis, history and physical.

d. Laboratory procedures; appropriate pre-operative labs within seven (7) days of procedure.

e. Consent form.

The surgeon must be in the operating room and ready to commence operation at the scheduled time, and in no case will the operating room be held longer than l5 minutes after the scheduled start time. If no surgery is to follow, this rule does not apply. First cases must be scheduled to start no later than 8:00 AM if there is a "to follow" case. The operating surgeon shall determine the need for a qualified assistant and be responsible for scheduling the assistant no later than regular working hours the day before the surgery is scheduled. Physicians, physician's assistants, advanced nurse practitioners, and registered nurse first assistants that are qualified to be surgical first assistants must have completed the credentialing process. Operating Room Nurses currently on duty will not function as "First Assistants" for the Medical Staff.

All surgically removed specimens of patients of the Hospital will be referred to a staff pathologist who will examine the specimen by appropriate methods (microscopically, etc.) and cause to be produced a written report of his findings. Exceptions are as follows:

a. Infant prepuce from circumcision.

b. Hardware which is described and documented on the chart by the surgeon.

c. Readily identified foreign bodies (coins, screws, etc.) removed by endoscopy and documented by the endoscopist.

d. Placenta and cord in normal term deliveries of full term infants without anatomic anomalies. Also, placenta of term C-section infants when the infant is normal and there has been no preeclampsia or abnormal third trimester bleeding.

e. Arthroscopy fragments.

f. Small bone fragments without known pathology.

g. Vaginal mucosa.

h. Nasal cartilage.

i. Lens fragments.

The list of exceptions is permissive, not mandatory (i.e., attending surgeon may request pathologist examination of any specimen removed at surgery).

The appropriate Service committee shall be empowered to formulate appropriate rules regulating outpatient surgery.

2. **Anesthesia Service Rules and Regulations**
All services along the continuum of anesthesia services provided will be organized under a single Anesthesia Service. The Anesthesia Services will be directed by a qualified physician (MD/DO) and implemented in every hospital department and setting

that provides any type of anesthesia service.

A pre-anesthesia evaluation must be performed by someone qualified to administer anesthesia for each patient who receives general, regional, deep sedation or other monitored anesthesia. The pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the 48 hour time frame.

In accordance with current standards of anesthesia care, the pre-anesthesia evaluation of the patient includes, at a minimum: Review of the medical history, including anesthesia, drug and allergy history; interview and examination of the patient; notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk); identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access); additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation); development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. An intraoperative anesthesia record, at a minimum, includes: name and hospital identification number of the patient; name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner; name, dosage, route and time of administration of drugs and anesthesia agents; techniques(s) used and patient position(s), including the insertion/use of any intravascular or airway devices; name and amounts of IV fluids, including blood or blood products if applicable; timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

A post anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia. The calculation of the 48-hour time frame begins at the point the patient is moved into the designated recovery area. Except in cases where post-operative sedation is necessary for the optimum medical care of the patient (e.g., ICU), the evaluation generally would not be performed immediately at the point of movement from the operative area to the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. The evaluation can

occur in the PACU/ICU or other designated recovery location.

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including: respiratory function, including respiratory rate, airway patency, and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature; pain; nausea and vomiting; and postoperative hydration. Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

3. **Pediatric Service Rules and Regulations**
   The Pediatric Service is responsible for providing consultation, evaluation and maintaining high standards of pediatric and newborn care. In the interest of providing assistance and consultation regarding care for the high risk newborn, the following conditions are provided for the prompt identification of infants at risk:

    a. Weight less than 2500 g at birth or gestation less than 36 weeks.
    b. Small for gestational age status.
    c. Perinatal asphyxia.
    d. Apgar score less than 4 at 5 minutes with clinical evidence of neurologic dysfunction.
    e. Delay in onset (or loss) of spontaneous respiration for more than 5 minutes requiring mechanical ventilation.
    f. Clinical evidence of central nervous system abnormalities, i.e., seizures, hypotonia, or intraventricular hemorrhage.
    g. Hyperbilirubinemia of greater than 20 mg/dl in non-sick, term neonates (the level of hyperbilirubinemia that causes deficits in premature neonates is unknown.)
    h. Specific genetic, dysmorphic, or metabolic disorders or a history of such disorders in the infants, a sibling, or other relative.
    i. History of prenatal or newborn infection.
    j. Psychosocial abnormalities, i.e., infants of drug addicted or alcoholic mothers.

4. **Perinatal / Gynecology Service Rules and Regulations**
   The Obstetric and Medical Gynecology Service is accountable for providing responsible care and evaluation with a high standard of obstetrical and gynecological care.

   In the interest of providing assistance and supervision of high risk obstetrical patients, the following conditions are listed for the prompt identification of high risk patients:

    a. Insulin dependent diabetes mellitus.
    b. Severe toxemia of pregnancy.
    c. Serious cardio-respiratory disease.
    d. Intrauterine growth retardation.

e. Serious renal disease.

f. Premature labor (prior to 36 wks. gestation).

g. Multiple gestation.

h. Drug addiction.

i. Premature rupture of amniotic membranes.

j. Post-maturity.

k. Epilepsy.

l. Hyperthyroidism.

m. Hypothyroidism.

n. Acute hypertension.

o. Sickle cell anemia.

p. Toxoplasmosis.

Regarding obstetrical care, the practitioner must be immediately available at all times while the oxytocin is running. From a practical standpoint this means that he shall be in the hospital or in his office and be immediately available. ACOG standards will be followed in the administration of oxytocin.

It is the responsibility and liability of the obstetrician to discuss with his or her patient the need to choose a physician to take care of the newborn. The primary physician is in charge and responsible for the patient's management and treatment.

5. **Family Practice Service Rules and Regulations**
Family Practice is a separate discipline of medicine devoted to primary comprehensive medical care of people not restricted by age or organ systems. The family practitioner is involved in the management of all the health problems of his patient whether he manages the problems by himself or utilizes consultants or other allied health professionals.

6. **Emergency Service Rules and Regulations**
The Medical Staff's method for providing medical coverage for the Emergency Department (ED) is set forth in Hospital policy. This policy shall be in accordance with the Hospital's plan for delivery of such services including delineation of clinical privileges for all physicians who render care.

All patients with multiple system or major injury must be evaluated by the Trauma Service and/or other appropriate Surgical Service(s). The surgeon responsible for the overall care of the patient must be identified. Trauma patients who are admitted to the hospital by a specialty other than general surgery will be seen by a general surgeon during the patient's admission. This consultation will occur within 24 hours of admission.

An appropriate medical record shall be maintained for every patient receiving care through the ED, and if admitted, be incorporated in the patient's hospital record. Records on patients discharged or transferred from the ED will be filed in the appropriate area in the Health Information Management Department. The record will include the following:

a. A demographic face sheet.
b. Information concerning the time of arrival and who transported patient.
c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.
d. Description of significant clinical, laboratory and radiological findings.
e. Diagnosis.
f. Treatment given.
g. Condition of the patient on discharge or transfer.
h. Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.

7. Telemedicine Service Rules and Regulations

Patients 18 and older admitted as ICU status will have mandatory critical care consults. The telemedicine critical care physician will act as a consultant, not the primary physician. The telemedicine physicians will round and direct procedures related to critical care as applicable. The goal is a collaborative approach to improve patient care and guide appropriate use of resources.