RULES AND REGULATIONS

OF THE

PROFESSIONAL STAFF

OF

COOK CHILDREN'S MEDICAL CENTER

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TABLE OF CONTENTS

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DEFINITIONS

In addition to any definitions below, the Definitions in the Professional Staff Bylaws shall apply to these Rules and Regulations:

"Admitting Practitioner" means the Staff Practitioner that orders the admission of the patient to the Center.

"Attending Practitioner" means the Staff Practitioner who has primary responsibility for the patient during hospitalization until transfer to another Attending Practitioner or discharge, and includes his/her Practitioner designee (Responsible Practitioner).

"Responsible Practitioner" means a Staff Practitioner caring for the patient at any time during hospitalization, including a Staff Practitioner covering for the Attending Practitioner.

I. INTRODUCTION

A. General

The following Rules and Regulations have been adopted by the Staff with the objective that patient care and the Center's services may be maintained at a high level of excellence.

Except in an emergency, no patient may be treated in any of the Medical Center's facilities (Operating Room, Laboratory, X-ray, Physical Therapy, Outpatient Clinic, etc.) unless admitted to the Center as an inpatient or outpatient.

The Attending Practitioner shall be considered the primary practitioner responsible for the care of the patient. The Attending Practitioner remains responsible for the care of the patient until a transfer of care is clearly documented in the medical record.

B. Enforcement and Discipline

The Medical Board shall have the authority, as provided in the Bylaws, to impartially enforce these Rules and Regulations.

II. MEDICAL RECORDS

A. General

No entry shall be made in the medical record by any person unless he/she is authorized to make entries in medical records by the System Medical Record Committee and the Medical Board. All entries shall be made in accordance with the guidelines and policies established by the System Medical Records Committee. No medical record documentation form or tool shall be used unless such form or tool has been approved by the System Medical Records Committee according to established policies.

The Attending Practitioner shall be responsible for the preparation of a complete, accurate and legible medical record for each patient except that other practitioners such as,

consultants, surgeons and anesthesiologists, who participate directly in the patient's care shall be responsible for appropriate parts of the medical record. The Attending Practitioner is responsible for coordinating the patient's care during the admission, including reconciling medications and other treatments during transition of care to other practitioners or other settings of care. The medical record shall be completed within fourteen (14) days following the visit or discharge.

Active Staff Practitioners will obtain training in order to access and use the electronic medical record. All Practitioners may use electronic signature to sign the dictated admission history and physical, consultation notes, operative notes, discharge summaries and other electronically scanned documents as functionality becomes available.

B. History and Physical Examination

1. General

A complete history and physical examination shall be performed on all inpatients, observation patients, patients receiving sedation or anesthesia, and any patient admitted for an overnight stay for any reason. A Staff physician (or oral surgeon with appropriate privileges for his/her own patients) shall perform and place in the medical record a complete history and physical examination within twenty-four (24) hours of admission/observation.

Advanced practice nurses and/or physician assistants credentialed to perform an admission history and physical examination will be allowed to do so. Histories and physical examinations performed by an advanced practice nurse or a physician assistant must be authenticated by the author within twenty-four (24) hours.

If a history and physical examination has been performed no more than thirty (30) days prior to admission, it may be used provided it was recorded and signed by a Staff physician member and an update note is documented in the record, within twenty-four (24) hours of arrival, but prior to any surgery or procedure involving anesthesia. The update note must include any changes or additions or a note that there are none. The update note may be documented on a "Short Stay Record" or "Progress Note".

- A history and physical examination documented at the time of admission is current for the entire admission.

The Attending Practitioner is responsible for all aspects of the history and physical examination. The Emergency Department Record serves as the history and physical examination for Emergency Department patients. If the patient is admitted for psychiatric services through the Emergency Department, the physical assessment/examination portion of the Emergency Department Record may serve as the physical examination for the admitting history and physical examination.

The following procedures are exempt from the requirement to perform a history and physical examination:

a. IV Infusions
b. G-button changes
c. Minor procedures – such as circumcision, ingrown toe nails or soft tissue foreign body removals using only local anesthesia

2. Required Elements

Practitioners (or advanced practice nurses or physician assistants) are responsible for providing the following documentation:

- Chief patient complaint
- Details of the present illness or condition including, as relevant, assessment of the patient's emotional, behavioral and social status
- Relevant past social and family histories appropriate to the patient's age
- Inventory of body systems
- Physical examination
- Diagnosis or problem list with a plan of care

The following elements are to be part of the Nursing Assessment:

- An evaluation of the patient's developmental age
- Consideration of educational needs and daily activities, as appropriate
- The parent's report or other documentation of the patient's immunization status
- The family/guardian expectations for, and involvement in, the assessment, treatment and continuous care of the patient.

The elements of the history and physical examination must be documented in the electronic medical record. For outpatient procedures or observation, the short stay form, the sedation procedure record and/or other approved forms are acceptable for documenting the history and physical. If changes in the patient's condition result in an admission, a progress note must document the reason for the change in level of care.

3. Surgery Patients

A history and physical examination (generated by dictation, Electronic Medical Records or handwritten using the approved "H&P Longform") must be documented before a surgical procedure is performed. Except in documented emergency situations, no patient may be taken to surgery without a history and physical examination on the patient's record. If a history and physical examination is not recorded before the stated time for surgery, the surgeon will be contacted to complete the history and physical examination as soon as possible and prior to the surgery. Exception to this policy is made only in case of an emergency which threatens the welfare of the patient, and is documented in the medical record by the attending surgeon. In this event, the operating room will be notified. The history and physical examination will then be completed as soon as possible following the procedure.

4. Dental Patients

The dentist or oral surgeon shall record a detailed dental history which justifies admission, a detailed description of the examination of the oral cavity and a preoperative diagnosis. Unless granted privileges to perform medical histories and physical examinations, a dentist or oral surgeon shall secure the services of a Staff physician to perform a history and physical examination and prompt evaluation within twenty-four (24) hours of admission and prior to the performance of any therapeutic or diagnostic intervention, to determine the risk and potential effect of any proposed oral surgical procedure on the patient. A Staff physician will be responsible for the care of the patient's general medical condition during the admission for any condition or illness beyond the scope of practice of the dentist or oral surgeon. The dentist or oral surgeon shall be responsible for securing the services of the Staff physician(s) and ensuring compliance with the requirements of this section.

C. Inpatient Records

A medical record shall be maintained for all patients treated in the Center. All medical records shall contain adequate information to identify the patient, support the diagnosis, justify the treatment and hospitalization, document the course and results accurately, and facilitate the continuity of care among the health care providers involved. The inpatient medical record shall contain at least the following:

1. The patient's name, address, date of birth, and the name of any legally authorized representative;
2. The patient's legal status, for patients admitted to the psychiatric floor;
3. Emergency care, if any, provided to the patient prior to arrival;
4. The record and findings of the patient's assessment;
5. The history and physical examination and a statement of the conclusion or impressions drawn from the history and physical examination;
6. The admitting diagnosis or diagnostic impression;
7. The reason or reasons for admission or treatment;
8. The goals of treatment and the treatment plan;
9. Evidence of known advance directives;
10. Evidence of informed consent for procedures and treatments for which informed consent is required by Medical Center policy;
11. Diagnostic and therapeutic orders, if any;
12. All diagnostic and therapeutic procedures and tests performed and the results, including laboratory, pathology and radiology reports;
13. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
14. Progress notes made by Staff members and other authorized individuals, including nurses notes and vital signs;
15. All reassessments and revisions to treatment plan;
16. Clinical observations, including the results of therapy and treatment and any complications;
17. Consultation reports;
18. Every medication ordered or prescribed for a patient;
19. Every dose of medication administered and any adverse drug reactions;
20. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
21. All relevant diagnoses established during course of care, including final diagnosis;
22. Conclusions at termination of hospitalization;
23. Any referrals/communications made to external or internal care providers and to community agencies; and
24. Discharge summary (see required content under Section L below).

D. Anesthesia/Sedation Record

The anesthesia/sedation record shall include documentation of at least the following:

1. The pre-anesthesia evaluation of the patient performed by the anesthesiologist or nurse anesthetist, including: interview and examination of the patient; evaluation of the patient's medical history, including previous drug and allergy history and anesthesia experience; identification of any potential anesthesia problems; notation of anesthesia risk; additional pre-anesthesia evaluation if applicable; 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 legally authorized representative) of the risks and benefits of the delivery of anesthesia; and any other pertinent findings documented within forty-eight (48) hours

prior to surgery (the delivery of the first dose of medication for the purpose of inducing anesthesia marks the end of the 48-hour time period). Except in emergency cases as described above, this evaluation shall be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

2. A review of the patient's condition immediately prior to induction of anesthesia.

3. An intraoperative record of all events taking place during induction of, maintenance of and emergence from anesthesia, including: identification of patient; names of practitioners who administered anesthesia and, as applicable, name and professional of the supervising anesthesiologist or operating practitioner; name, dosage, route, and time of all anesthetic agents and other drugs; name and amounts of intravenous fluids and blood or blood fractions administered; time-based documentation of vital signs as well as oxygenation and ventilation parameters; any complications, adverse reactions, or problems during anesthesia time, including time and description of symptoms, vital signs, review of affected symptoms, treatments rendered, and patient's response to treatment. The record shall correlate with the controlled substance administration record.

4. Post-anesthetic visit(s) after the patient recovers from anesthesia, before transfer from recovery, including at least one (1) note by the anesthesiologist or anesthetist administering the anesthesia pursuant to established protocol describing: the presence or absence of anesthesia-related complications; evaluation for recovery from anesthesia; level of activity; respiratory function including respiratory rate, airway patency, and oxygen saturation; cardiovascular function including pulse rate and blood pressure; LOC; temperature; pain; postoperative hydration; and skin color assessment for circulation.

    a. With respect to inpatients, an additional post-anesthesia evaluation for proper anesthesia recovery shall be performed and documented after transfer from recovery and within forty-eight (48) hours after surgery (begins at the point the patient is moved into the designated recovery area) by the anesthesiologist or anesthetist administering the anesthesia, or a designee who is qualified to administer anesthesia, using written criteria for post-operative monitoring of anesthesia as set forth by the Department of Anesthesia in written policy.

    b. With respect to outpatients or observation patients, immediately prior to discharge from the post anesthesia care unit, a post-anesthesia evaluation for proper anesthesia recovery shall be performed and documented by the anesthesiologist, CRNA or a designee who is qualified to administer anesthesia, using written criteria for post-operative monitoring of anesthesia as determined by the Department of Anesthesia.

5. CRNAs shall be supervised by Staff anesthesiologists in accordance with the Department of Anesthesia written policy.

E. Operative/Invasive Procedures

1. Surgery is performed only after:

    a. a current and pertinent history and physical examination is recorded in the medical record as described in Section B above;

b. the preoperative diagnosis has been completed and recorded in the patient's medical record;

c. any indicated diagnostic tests have been completed and recorded in the medical record; and

d. there is a preanesthesia assessment within forty-eight (48) hours prior to surgery as described in Section D above.

In an emergency situation in which there is inadequate time to record the history and physical examination prior to surgery, a brief note, including the preoperative diagnosis, is recorded before surgery.

2. Prior to any transfer to a different level of care (such as recovery, PICU, NICU), an operative progress note shall be entered in the record immediately after surgery to provide pertinent information for any individual required to attend to the patient. The note shall record the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss, specimens removed, and postoperative diagnosis. Alternatively, in lieu of completing an operative progress note, the primary surgeon may elect to complete a full operative report as set forth in Section (E)(3) below. Either the operative progress note or the full operative report must be completed and authenticated prior to any transfer to a different level of care.

3. Each primary surgeon shall record a complete operative report for each inpatient and outpatient within twenty-four (24) hours following surgery. Operative reports shall include: patient identification; date and times of the surgery; type of anesthesia; detailed accounts of the findings at surgery and the surgical techniques; and as specifically as possible the operative procedure performed. The report shall include any specimen removed or altered; prosthetic devices, grafts, tissues, transplants or devices implanted, if any; estimated blood loss, and the pre-operative and post-operative diagnosis. The report should describe any unusual events or complications and the management those events. The primary surgeon and any assistants shall be identified in the operative report and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner.

4. The completed operative report is authenticated by the surgeon and included in the medical record as soon as possible after surgery. If the surgeon elects to complete a full operative report in lieu of an operative progress note, as allowed by Section (E)(2) above, the operative report must be authenticated prior to any transfer to a different level of care.

5. Postoperative documentation shall at least include a record of the following:

a. vital signs and level of consciousness;

b. medications, IV fluids, blood and blood components;

c. any unusual events or postoperative complications including blood transfusion reactions, and the management of those events;

d. the patient's discharge from post-anesthesia recovery by the anesthesiologist, nurse anesthetist, or their designee in accordance with established protocol; and

e. identifies the practitioner responsible for discharge.

6. Dental patients. A patient admitted for dental care is a dual responsibility which involves the Staff dentist or oral surgeon and a Staff physician. Staff anesthesiologists with appropriate privileges may assume Staff physician responsibility for oral surgery and dental patients during outpatient oral surgery procedures. If such patients are admitted to the Center, the general medical condition of those patients will be transferred to a Staff hospitalist physician.

Unless granted privileges to perform medical histories and physical examinations, the dentist or oral surgeon is responsible for securing the services of a Staff physician to perform a history and physical examination as described above. The dentist or oral surgeon is also responsible for documenting a complete operative report describing in detail the elements required in Section 3 above.

Responsibilities of the Staff physician include those listed in this Section II, if the patient is admitted for any condition or illness beyond the scope of practice of the dentist or oral surgeon. Discharge of the patient shall be on order of the Staff dentist or oral surgeon, unless the patient has had medical complications, in which event, approval of the discharge order must be recorded in the medical record by the Staff physician.

F. Non-Surgical Outpatients and Clinic Patients

Non-surgical outpatients include those patients seen in the Center for treatments or diagnostic procedures which do not involve surgery. Clinic patients include those patients who receive ambulatory care in Center clinics.

1. Medical Record

An appropriate medical record shall be created for every non-surgical outpatient visit. The contents of such medical record shall be in accordance with guidelines established by the System Medical Record Committee. The System Medical Record Committee shall review and revise, as necessary, the guidelines for such medical records. Such guidelines shall be in accordance with accrediting standards and applicable law.

2. Policies and Procedures for Non-Surgical Outpatients

The Staff, through its Divisions and committees, shall develop appropriate Policies and procedures governing the care of non-surgical outpatients. All such policies and procedures shall be subject to approval of the Medical Board and Governing Body.

3. Clinic Patient Records

Center clinics shall maintain patient medical records in a uniform and consistent manner. The Center clinic record shall document every patient visit. The medical record of patients receiving continuing ambulatory care services includes a list of known significant diagnoses and conditions, any operative or invasive procedures, any drug allergies or reactions, and medications (including current prescriptions, over-the-counter drugs and herbal preparations). This list is initiated and maintained for each patient no later than the third visit, and is stored in the same location in the patient medical records.

G. Emergency Care

An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's hospital record, if such exists. The record shall include:

1. Adequate patient identification information;
2. Information concerning the time of the patient's arrival, means of arrival and by who transported;
3. Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to arrival at the Medical Center;
4. Pertinent physical assessment;
5. Diagnostic and therapeutic orders;
6. Clinical observations, procedures performed, including the results of treatment;
7. Reports of procedures and tests, and their results;
8. Diagnosis or impression;
9. Condition of patient on discharge or transfer, including any required transfer documentation;
10. Patient disposition and any instructions given to the patient and/or family for care;
11. Referrals to practitioners or providers of services outside the Medical Center;
12. Any instance of leaving against medical advice or leaving prior to receiving a screening examination; and
13. Conclusions at termination of treatment, including:
    a. final disposition;
    b. patient's condition at discharge;
    c. instructions for follow up care; and
    d. authorization by the patient/legally authorized representative that a copy of the emergency services provided be made available to the practitioner or organization responsible for follow up care.

Each patient's medical record shall be signed by the Practitioner in attendance who shall be responsible for its clinical accuracy. The ED Provider Note must be completed within seventy-two (72) hours following a patient's discharge from the Emergency Department, admission to the Medical Center, or transfer to an outside facility.

H. Progress Notes and Rounds

Pertinent progress notes shall be recorded at the time of observation by the Attending Practitioner or his/her designee. These notes shall be sufficient to permit continuity of care and transferability of the patient. The patient must be observed and evaluated at least daily by the Attending Practitioner or a Responsible Practitioner. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as correlated with results of tests and treatment. The Discharge Summary shall be sufficient to constitute a progress note for purposes of this section for the last day of the patient's admission.

If an Attending Practitioner is assigned from an Emergency Department admission, the Attending Practitioner must see the patient and document a progress note the next morning, unless an earlier visit is medically indicated.

I. Consultations

Requests for consultation must be recorded in the medical record as an order for consultation. Consultations shall include a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and

recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations.

J. Practitioners' Orders

The following rules shall apply to orders given by Professional Staff members:

1. For the purposes of this Section, "Responsible Practitioner" shall include the Attending Practitioner and any Professional Staff member covering her/his practice.

2. Only members of the Professional Staff (or Practitioners who have been granted temporary privileges in accordance with the Bylaws) **or their authorized representative** may issue orders for treatment with the following exception: outpatient laboratory or radiology diagnostic procedures may be performed if referred with written orders from a Texas licensed practitioner, physician or dentist.

3. All authorized orders for treatment should be entered directly into a computerized order entry system by the ordering Practitioner and must be complete, dated, timed and signed. Handwritten, signed orders and verbal orders, when necessary, will be considered valid if legible, complete, dated, timed, and signed as set out below. Verbal orders should only be used infrequently when it is not possible or practical for the Practitioner to write the order or enter it in the computer. A verbal order may be entered into the medical record by an RN/LVN or authorized health care provider as described below. A verbal order must be signed on the next visit or no later than forty-eight (48) hours, whichever is sooner. If the ordering Practitioner is not able to authenticate the verbal order within the required time period, a Responsible Practitioner may co-sign the verbal order and take responsibility for the order being complete, accurate, and final. Verbal orders may not be co-signed for practice partners solely for convenience. The authentication signature must be timed and dated.

   All verbal and telephone orders will be read back to the physician after being recorded by the appropriate health care provider and noted as "VORB" or "TORB" with the ordering Practitioner's and authorized provider's names recorded in the medical record. Orders received for outpatient testing may also be written as a prescription or received by phone. Orders for outpatient testing shall also be verified by having the person receiving the order read back the order and must be authenticated within forty-eight (48) hours. The ordering Practitioner is encouraged to fax the written order to the appropriate department.

   The following licensed or certified health care providers are authorized to accept verbal orders:

   a. Registered nurse;
   b. Certified registered nurse anesthetist;
   c. Vocational nurse;
   d. Transport paramedic;
   e. Pharmacist;
   f. Respiratory therapist for orders related to respiratory care;
   g. Physical therapist for orders pertaining to physical therapy treatments;
   h. Occupational therapist for orders pertaining to occupational therapy treatments;
   i. Speech/language pathologist for orders pertaining to speech therapy treatments;

j. Audiologist for orders pertaining to audiology evaluation and treatments;
k. Dietitian for nutrition and dietetic orders; and
l. Radiology technologist for exams and for medication orders from radiologist and referring physicians.

4. A Practitioner's orders which are handwritten and applicable to a given patient, shall be documented in detail on the Physician's Directions form of the patient's record, timed, dated, and signed by the ordering Practitioner at the time of entry and must be legible.

5. A member of the Staff utilizing an authorized representative to transmit orders on a patient to the Center shall be responsible for identifying her/his representative to the Center. The authorized representative is responsible for identifying her/himself when transmitting orders. All orders transmitted by an authorized representative shall include the name of the Practitioner and authorized representative.

6. Restraints and Seclusion. The use of restraints and seclusion shall be limited to the extent reasonably possible for patients who require them and when used shall be done in accordance with Center policy.

K. Diagnosis

The Admission Diagnosis is the condition requiring the admission of the patient to the Center and shall be recorded in the medical record at the time of admission.

The Principal Diagnosis is established after study and evaluation. The Principal Diagnosis shall be recorded in full in the medical record at the time of discharge and on the discharge summary, short stay record, or face sheet without the use of symbols or abbreviations. The Principal Diagnosis and any secondary diagnoses and complications shall be documented and the entry dated, timed and signed by the Responsible Practitioner for the patient at the time of discharge.

L. Discharge Summary

A Discharge Summary shall be entered into the medical record for all patients hospitalized over forty-eight (48) hours. A final progress note may be substituted for a Discharge Summary only for those patients with problems and intervention of a minor nature who require less than a forty-eight (48) hour period of hospitalization.

For all patients, the content of the Discharge Summary shall be sufficient to justify the diagnosis and warrant the treatment. Discharge summary may be dictated and shall include the following:

1. the reason for hospitalization;
2. the significant findings;
3. the procedures performed and the treatment rendered;
4. the patient’s condition on discharge and outcome of hospitalization; and
5. disposition of care and provisions for follow up care and any specific instructions given the patient and/or family.

A transfer summary may be substituted in the case of the transfer of the patient to a different level of hospitalization within the Center.

M. Standard Electronic Order Sets and Preprinted Orders

1. Practitioners may create standardized order sets to use as an ordering tool in the electronic medical record which are subject to the same time, date and authentication requirements as other orders. These sets must be approved by the System Medical Record Committee according to its established policies. The authorizing Practitioner(s) shall review the order sets no less than every twelve (12) months and revise then, if necessary.

2. The use of specific preprinted paper orders must be timed, dated and signed by the Practitioner on the last page, with the last page also identifying the total number of pages in the set, and signing or initialing any other pages where selections or changes have been made. The use may also be ordered by verbal order and recorded by authorized personnel on the Practitioner's directions, in which case the Practitioner must countersign such verbal orders within forty-eight (48) hours as set out above. The Practitioner shall review her/his preprinted orders no less than every twelve (12) months and revise them, if necessary.

N. Symbols and Abbreviations

Medical record entries shall not contain abbreviations or symbols identified on the current "DO NOT USE" abbreviation list.

O. Inappropriate Entries

Documentation in the medical record shall be accurate and pertinent to the patient's condition and treatment. All inappropriate entries may be referred to the Credentials Committee and/or Peer Assistance Committee.

P. Date, Time and Authentication of Entries

All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated (by signing) by the appropriate Practitioner at the time of entry. When the Practitioner signs or authenticates an entry in the medical record, the Practitioner is certifying that the entry is accurate.

Those not requiring co-signature:

- All physicians and dentists with Staff privileges
- All health care professionals employed by the Medical Center, as long as the entry is within the scope of practice of the individual
- Allied Health Professionals who require practitioner supervision and direction - Observations, treatments, recommendations, etc. may be recorded on the progress notes or the medical record on each visit with the patient.

Those requiring co-signature:

- Resident Physicians **in accordance with their authorization to practice at the Center.**

Q. Corrections

Any change or addition in a handwritten record shall be clearly marked as a change or addition and signed and dated by the author. A line should be placed through any written error with the author's initials and the date and time of noting the error.

It is never appropriate to obliterate a handwritten entry in the medical record, to make a change not clearly marked as a change, or to remove or rewrite any page or form in the medical record. Any such action may be referred to the Credentials Committee for review.

R. Medical Record Completion and Enforcement Procedure

Medical records must be completed within fourteen (14) days following discharge or date of visit. Medical record completion requirements shall be enforced as provided in the Center policy approved by the Medical Board. Sanctions for failure to complete medical records in a timely manner may include automatic suspension of clinical privileges and/or automatic termination of Professional Staff membership (see Article XII of Professional Staff Bylaws).

S. Filing Incomplete Record

A medical record shall not be permanently filed until it is completed by the Responsible Practitioner or until it is ordered filed by the System Medical Record Committee.

T. Release of Original Records

All original medical records are the property of the Center and shall not be removed from the care and custody of the Center except as required by a subpoena duces tecum, court order or statute.

All requests for copies of Center medical records shall be forwarded to the Medical Records Department.

U. Practitioners' Access to Medical Records

In case of readmission of a patient, all previous medical records shall be available for the use of the Attending Practitioner. This shall apply whether the patient is attended by the same practitioner or another.

Access to medical records of patients shall be afforded to members of the Professional Staff for quality review, utilization review, and medical peer review for the Professional Staff and Center, and for bona fide study and research projects approved by the Institutional Review Board subject to any confidentiality limitations imposed by law or Center policy. Patient records are confidential and privileged under Texas law and may not be redisclosed except as permitted by law.

III. ADMISSION OF PATIENTS

A. Patient Age

As a pediatric medical center, the Center recognizes a primary responsibility to pediatric patients from birth through twenty-one (21) years of age. Patients more than twenty-one (21) years of age may be admitted from time to time in accordance with Center policy or by special arrangement approved by the administrator-on-call, if space permits.

B. Admitting Privileges

A patient may be admitted to the Center only by a member of the Staff with admitting privileges. All practitioners shall be governed by the official admitting policies of the Center.

C. Attending Practitioner's Responsibility

A member of the Staff shall be responsible for the medical care and treatment of each patient in the Center, for accurately and promptly completing the medical records, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and, if authorized, to relatives of the patient.

D. In-House Patient Transfers

In-House transfers are identified as transfers:

- From any area to an Intensive Care Unit
- From Emergency Department to appropriate patient bed
- From Short Stay or Observation to appropriate patient bed
- From Intensive Care or Transitional Care Units to general care areas
- From temporary placement in an inappropriate geographic or clinical service area to more appropriate area for that patient
- Change of Attending Practitioner and/or clinical service

No patient will be transferred without approval of the Attending Practitioner except in an emergency when the Attending Practitioner cannot be reached.

Whenever a patient is transferred, an order for the transfer and a progress note explaining the need for the transfer shall be entered in the medical record. Location transfers shall be effective when the order is entered in the medical record and the patient is received at the new location.

When transferring to a different Practitioner, the transfer shall be effective when the order is entered in the medical record and acknowledgement of the transfer by the receiving Practitioner is documented. The transferring Attending Practitioner shall remain responsible for the patient, unless the transfer of responsibility is clearly documented in the medical record.

When transferring patient care, the transferring Practitioner shall review and, if necessary, edit the patient's current orders. The transferring Practitioner shall document in the medical record that such a review of the current orders has occurred.

When transferring patient care, the receiving Practitioner shall review and, if necessary, edit the current orders that have been reviewed by the transferring Practitioner. The receiving Practitioner shall document in the medical record that such a review of current orders has occurred.

Patient transfers to another level of care require a complete medication order, including medication reconciliation.

E. Admitting Diagnosis

Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated by the Admitting Practitioner and entered in the medical record.

F. Emergency Admissions

Practitioners admitting emergency cases shall document in the history and physical examination facts that clearly justify the patient being admitted on an emergency basis. Such

findings must be recorded in the patient's medical record as soon as possible after admission, and no later than twenty-four (24) hours after admission.

G. Emergency Patients without Admitting Practitioners

If a patient who is to be admitted from the Emergency Department does not have an existing relationship with a Staff Practitioner, the ED physician will consult with a Practitioner in the appropriate specialty to arrange an acceptance of an admission as described in Section H. below. The Practitioner on call for the appropriate specialty or the Inpatient Pediatric Service will be assigned.

1. The Attending Practitioner assigned from the Emergency Department must see the patient and enter a progress note the next morning, unless an earlier visit is medically indicated.

2. Admission orders may be entered into the medical record by the ED physician following consultation with the Attending Practitioner. By noon the next day the Attending Practitioner shall review and, if necessary, edit the patient's current orders. The Attending Practitioner shall document in the medical record that such a review of the current orders has occurred.

H. Specialty Call Schedules

1. Specialty call coverage obligations are set out in the Bylaws and apply regardless of the distance of the Practitioner's practice location from the Center.

2. Exceptions to specialty call coverage may be granted by the Medical Board for:

   a. Requesting members sixty (60) years of age and older who have practiced in the Center for at least five (5) years, depending on the Center's and community's needs in the medical specialty or subspecialty;

   b. Those areas specifically covered by an exclusive contract; or

   .

   c. Requesting Active and Senior Active Staff members who have practiced at the Center for twenty-five (25) years or longer prior to age sixty (60), depending on the Center's and community's need for the medical specialty or subspecialty.

   All exemptions are subject to the approval of the Governing Body. The Medical Board may also revoke any exemption based on Center and/or community need.

3. It is the responsibility of the Practitioner assigned on ED call for their specialty to arrange for coverage by another Practitioner within the same specialty and holding equivalent privileges at the Center should he/she not be available for any reason. The originally assigned "on call" Practitioner is responsible for appropriately notifying the ED and any pertinent patient care unit of such changes in the schedule.

4. Failure of any Practitioner on call to respond within thirty (30) minutes to the ED or any patient care unit OR provide coverage as required shall be reported to the practitioner's Division Chief, Vice-Chief, Staff President, Chief Medical Officer, or Medical Director.

5. If a Practitioner shares call with individuals not on the Staff, it is his/her responsibility to assure that coverage by an appropriate Staff member will be available and provide coverage at the Center.

6. Divisions will be allowed to develop their own call schedule which they will provide to the ED at least two (2) weeks prior to the first of each month. Those Divisions who fail to develop a schedule will have a schedule developed for them by their respective Division Chief and will abide by this schedule as set forth above.

See VI.A. for additional detail.

I. Priority of Discharge and Admissions

The nursing supervisor will be responsible for identifying and prioritizing patients for possible discharge, and for notifying the Responsible Practitioner for approval to discharge.

The Admitting Office will admit patients based on the following order of priorities:

1. Emergency Admission: Those patients who are designated by the Attending Practitioner as patients who need immediate Center care and whose condition would suffer if such admissions were delayed. Willful or continued misuse of this category of admission will be brought to the attention of the Quality Improvement/Case Review Committee for review.

2. Urgent Admissions: Those patients who warrant hospitalization within twenty-four (24) to forty-eight (48) hours and whose conditions would suffer if admission were delayed beyond that period of time.

3. Reservation Admissions: Those patients already scheduled for surgery as well as other patients who have previously made reservations in advance of being admitted on a particular day.

4. Routine Admissions: Those patients who are elective admissions without reservations, involving all services.

J. Admission Laboratory Work

1. The Attending Practitioner or other appropriate Practitioner shall order indicated laboratory work.

2. If ordered, the patient's informed consent to testing for HIV infection or AIDS shall be documented in the appropriate form approved by the Medical Board and Board of Trustees. If a health care worker has been exposed to blood products or secretions from a patient, testing for HIV infection may occur without specific consent in accordance with the procedures in Center Policy MC 255.

K. Suicidal Patients and Potentially Harmful Patients or Parents

The Attending Practitioner shall be responsible for giving such information as may be necessary to protect the patient from self harm and to protect others whenever the patient's presence might be a source of danger from any cause.

For protection of patients, the Staff, the Nursing Staff, and the Medical Center, the following procedures are to be implemented in the care of the potentially suicidal patient:

1. A patient assessed to be at risk for suicide while on a medical floor will be placed on one (1) of two (2) levels of close observation status by an order from the Attending Practitioner. The Attending Practitioner will also order a consult from the psychiatrist on call to assess the patient and suicide risk. Initiation of close observation will be documented in the progress note. The patient's room will be searched and any potentially hazardous items will be removed. The patient will be restricted to the unit. Any change in the patient's assessment criteria will be reported to the charge RN and Attending Practitioner and be documented.

2. The two (2) levels of close observation status are:

    a. Patient checks every fifteen (15) minutes with the patient placed in a room near the nurses' station. Direct observation of the patient will occur every 15 minutes and be documented on the special observation flow sheet.

    b. One-to-One direct patient observation. The patient will be monitored by direct visualization by one-to-one (1:1) staff accompaniment. Staff will also escort patient to the bathroom and all unit areas. The one-to-one (1:1) observation will be documented on the close observation flow sheet.

        Observation may be provided by the unit staff (e.g.: unit assistant). If assistance with staffing is needed, the Psychiatry Department may be contacted.

L. Admissions to Intensive Care Unit

1. If any question as to the validity of an admission to or discharge from an Intensive Care Unit should arise, that decision is to be made through consultation with the Medical Director of the Intensive Care Unit.

2. The Attending Practitioner is required to document the need for continued Intensive Care Unit hospitalization after specific periods of stay as identified by medical audit and utilization criteria established by the applicable committee and the Medical Board. The documentation must contain:

    a. An adequate written record of the reason for continued hospitalization in an Intensive Care Unit (a simple reconfirmation of the patient's diagnosis is not sufficient); and

    b. Estimated period of time the patient will need to remain in the Intensive Care Unit.

3. Upon request of the Quality Improvement/Case Review Committee, the Attending Practitioner must provide written justification for the necessity of continued hospitalization of any patient hospitalized fourteen (14) days or longer, including the estimated number of additional days of stay and the reason therefore. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure to provide the requested documentation shall be referred to the Quality Improvement/Case Review Committee for review and recommendation.

IV. DISCHARGE OF PATIENTS

A. Responsibility

Patients shall be discharged only on the order of the Attending Practitioner (see Section II.E.6 on dental patients). The discharge order shall be documented in the medical record prior to discharge.

B. Failure to Discharge Patient

Upon the request of the Division Chief or the Quality Improvement/Case Review Committee or a committee that reports to that Committee, the Attending Practitioner must provide written justification for the necessity of continued hospitalization of any patient. This documentation must contain:

1. An adequate written record demonstrating the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

2. Estimated period of time the patient will need to remain in the Center; and

3. Plans for post-Center care.

This report must be submitted within twenty-four (24) hours of receipt of such request.

Failure to provide the requested documentation will be referred to the appropriate Division Chief or Quality Improvement/Case Review Committee or its designee for review and recommendation.

C. Patients Leaving AMA

Should a patient leave the Center against the advice of the Attending Practitioner or his/her designee, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Practitioner or his/her designee.

D. Patients Released on Pass

Patients admitted to the Center shall not be given leave of absence from the Center for more than twenty-four (24) hours until discharge, except for diagnostic or therapeutic treatment where facilities are not available in the Center. In such instance, a written order by the practitioner and consent of the Medical Director or Center President is required.

E. Death of a Patient

In the event of a Center death, the deceased shall be pronounced dead by the Attending Practitioner, or his/her Practitioner designee, within a reasonable time. The body shall not be released until an entry, including the date and time of death, has been made and signed in the medical record of the deceased. Policies with respect to dead bodies shall conform to Texas law.

F. Request for Autopsy

It shall be the duty of all Staff members to secure meaningful autopsies whenever possible in deaths that meet established criteria developed by the Staff. An autopsy may be performed only with a written consent, obtained in accordance with State law and Center policy. All

autopsies shall be performed by a Center pathologist or by a practitioner delegated this responsibility unless the death is reportable to the Medical Examiner or as requested by the patient's legally authorized representative. Provisional anatomic cause of death shall be recorded on the medical record within seventy-two (72) hours; the complete autopsy protocol will be made a part of the record.

V. GENERAL CONDUCT OF CARE

A. Drugs and Medication

1. All drugs and medications administered to patients shall be those listed in the latest editions of standard reference texts.

   Drugs for bona fide clinical investigations approved by the System IRB may be exceptions. These shall be in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospital and all regulations of the Federal Drug Administration.

2. All medications and drugs used shall be identified by name and dosage. Medications brought to the Center by the patient for the patient's use also shall be labeled and ordered in this same fashion and not by prescription number alone and in accordance with Center policy.

3. Patients sedated for procedures outside the direct purview of qualified anesthesia staff and the operating room/post-anesthesia recovery unit will be cared for in a standardized manner in accordance with Center Policy MC238 and other applicable policies as developed.

B. Verification of Surgical/Invasive Procedure Site

The Practitioner who is credentialed to perform a surgical or invasive procedure must be the individual who marks the site of the procedure and shall follow the process required by Center Policy PS 573.

C. Standing Delegation Orders and Delegation of Prescriptive Authority

1. Standing delegation orders for treatment of patients presenting themselves prior to being examined or evaluated by a Practitioner must: (i) be in writing; (ii) meet the requirements of the Texas Medical Board; and (iii) be approved by the Medical Director of the clinical unit where the orders are to be used.

2. Delegation of authority to carry out or sign prescription drug orders to advanced practice nurses and/or physician assistants must be documented in physician orders, standing medical orders, protocols or other written authorization for initiating medical aspects of care as required by the Texas Medical Board. Any physician delegating prescriptive authority must meet the supervision requirements of the Texas Medical Board, and must review and sign the orders/protocols with the APN and/or PA at least annually. A signed copy of the current written authority for each APN or PA must be provided to Medical Staff Services annually, and must also be available in the unit where the individuals practice. Delegation of prescriptive authority must be included in the clinical privileges granted to the APN or PA to be effective.

3. Clinical units of the Center which are facility based practices may document delegation of prescriptive authority to APNs or PAs using physician orders, standing medical orders, protocols or other written authorization prepared and signed by the

Medical Director of the clinical unit where the orders are to be used. Other physicians in the clinical unit who have authorized APNs or PAs to act under unit orders/protocols for their patients must document that consent in writing. Documentation of delegation of prescriptive authority must be reviewed and signed by the physician, APN and/or PA at least annually and maintained in the clinical unit. Delegation of prescriptive authority must be included in the clinical privileges granted to the APN or PA to be effective.

D. Consultations

1. Any qualified Practitioner with clinical privileges in the Center or his/her appropriately qualified designee with clinical privileges in the Center may be called for consultation within his/her area of expertise by another Staff Practitioner. Such requests must be recorded in the medical record as an order for consultation.

2. The Attending Practitioner or his/her designee is primarily responsible for requesting consultation, when indicated, and for calling in a qualified consultant. The Practitioner called for consultation or his/her designee shall respond to the request in a timely manner, as agreed upon by the Attending Practitioner and consultant in the context of the patient's condition.

E. Questioning Practitioners' Orders of Treatment

Any healthcare professional shall question a Practitioner's order when the order or treatment (or lack of order or treatment) is:

1. contrary to customary practice;
2. contrary to Center policy or Staff Policy;
3. contrary to patient or family wishes; or
4. believed to be unsafe.

In addition, any healthcare professional should seek clarification of any order which is unclear, incomplete or with which the healthcare professional is unfamiliar.

1. The healthcare professional who is to execute the order in question shall validate concerns regarding the orders through internal sources, including supervisors, policy/procedural manuals, reference books, and clinical resource persons.

2. If the healthcare professional who is to execute the order continues to be concerned, he/she shall contact the ordering Practitioner and describe the exact nature of the concern. If the ordering Practitioner declines to change the order and the healthcare professional remains concerned about the patient's well being, he/she shall contact the appropriate house supervisor.

3. If the house supervisor also believes that sufficient grounds exist for questioning the order, he/she shall contact the ordering Practitioner, if in the supervisor's opinion, there can be a meaningful discussion. In the event that it is not possible to contact the ordering Practitioner or the covering Practitioner or if, in the supervisor's opinion, the discussion with the ordering Practitioner was not satisfactory, the supervisor may contact the appropriate Division Chief. In the event that an emergency situation arises, a code shall be called in accordance with established procedures.

4. If the Chief of Division cannot be reached, the following should be contacted in the following order:

a. Vice Chief of Division
b. President of Professional Staff
c. A Vice President of Professional Staff

The Division Chief or his/her designee shall contact the ordering Practitioner or his/her covering Practitioner to attempt to clarify the situation. If no resolution is possible, the Division Chief (or other officer as noted above) shall be responsible for providing or retaining appropriate care for the patient.

5. The supervisor shall go to the floor, make a note in the Practitioner's Orders of any verbal order given him/her by the Chief of Division (or other Professional Staff officer). The healthcare professional shall implement or initiate the new order. The Chief of the Division (or other officer) shall countersign the order within twenty-four (24) hours. The Chief of Division (or other officer) shall inform the ordering Practitioner of changes made in the orders and assure continuity of care for the patient

6. The supervisor shall make a written report of all situations in which the orders being questioned require intervention by the Chief of Division (or other officer) to the appropriate quality review committee.

F. Obtaining and Documenting Informed Consent

It shall be the responsibility of the Attending Practitioner or Practitioner providing the treatment to obtain the informed consent to treatment, including blood transfusion, of his/her patients in compliance with Texas law and Center policy. Before obtaining informed consent, the risks, benefits, and potential complications associated with procedures as well as alternative options shall be discussed by the treating Practitioner with the patient and/or legally authorized representative. The nursing staff shall be available to assist such Practitioners in obtaining documentation of such consent on forms approved by the System Medical Records Committee.

Except in the case of life, limb or organ threatening emergencies, every patient treated or the patient's legally authorized representative shall sign a general consent for admission and treatment. After an emergency situation has ceased to exist, the patient or his/her legally authorized representative shall document consent for admission and treatment. In addition, all specific consents appropriate to the proposed treatment or procedure shall be documented by the Practitioner prior to the treatment.

G. Harassment

In addition to complying with the Center Code of Conduct and the provisions in the Professional Staff Bylaws, no member of the Professional Staff or Practitioner with clinical privileges shall degrade, berate, verbally or physically abuse, sexually touch or harass any employee, visitor, patient or other Professional Staff member. Any behavior which violates this section or creates an intimidating work environment or interferes with any employee's ability to perform his/her or her job or any retaliation for reporting behavior believed to be in violation of this section shall be referred to the Credentials Committee and/or Peer Assistance Committee for review and recommendation.

VI. EMERGENCY SERVICES

A. Specialty Coverage and Call Lists

The Staff through its Divisions shall establish a method of providing specialty coverage in the Emergency Department in accordance with the Center's basic plan for the delivery of such services.

The Emergency Department shall maintain a call list which includes all specialty and sub-specialty groups represented in the Staff that are available to the ED. It shall be the responsibility of each Division to create its call list in accordance with Section III., H. of these Rules and Regulations and shall communicate such lists to the Emergency Medicine Department. The Emergency Medicine Department shall distribute copies of the call list pursuant to the instructions of each specialty.

B. Responsibility of Call List Practitioner

It is the responsibility of the Staff member whose name appears on the call list for his/her specialty to respond to a call from the Emergency Department within thirty (30) minutes and be able to reach the Medical Center within a reasonable time. If such Staff member does not respond within thirty (30) minutes or refuses to respond or provide requested coverage, the Director of the Emergency Department (or his/her designee) shall notify any other Staff member on call for that individual. However, if there is no other Staff member on call, he/she shall notify the Chief of the Division of which the non-responding Practitioner is a Staff member, the Department Medical Director or the Chief Medical Officer. If those individuals cannot be contacted, the Emergency Department Director may contact the Vice Chief of the Division, or the Staff President. It is the responsibility of the Division Chief, Medical Director, Chief Medical Officer or Professional Staff officer contacted to provide another Practitioner to care for the patient.

The Practitioner on call is also responsible to accept the transfer of any patient with an emergency medical condition that requires the specialty services of the Practitioner on call, if the Practitioner has the capability to provide the services and the services are not available at the transferring hospital.

Any failure to respond or to provide specialty coverage shall be referred to the appropriate Division Chief or Department Medical Director for review and/or action.

Emergency services, including those provided by Practitioner on call and transfers from the ED, shall be in accordance with Center policy.

C. Major Multiple Trauma Patients

Major multiple trauma patients are those who have experienced multiple-system trauma. The Emergency Department shall determine which patients qualify as having multiple system trauma and shall call a trauma surgeon to care for such patients. The trauma surgeon shall assume responsibility for the patient and shall select subspecialists to assist in or assume the care of the patient.

D. Qualified Medical Personnel for Screening Examinations

For purposes of (1) performing an appropriate medical screening examination of an individual presenting to the Medical Center to determine whether the individual suffers from an emergency medical condition, and (2) completing the required physician certification for transfer of a patient with an emergency medical condition who has not been stabilized to

another facility for treatment at the direction of the Responsible Physician, the following professionals are deemed to be Qualified Medical Personnel (QMP):

a. Physicians on the Professional Staff of Medical Center;

b. Nurse Practitioners and Physician Assistants with documented assessment skills and orientation to medical screening criteria established by the medical and nursing directors of the Emergency Department or CARE Team (as applicable); and

c. For behavioral health conditions, all Psychiatrists, Licensed Professional Counselors (LPCs), master's prepared social workers (MSWs), doctorally prepared psychologists (PhDs) and those baccalaureate prepared registered nurses from the psychiatric unit with documented mental health assessment skills and orientation to mental health screening criteria established by the medical and nursing directors of the Psychiatric Department.

E. Disaster Plan

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Medical Center's capabilities, in conjunction with other emergency facilities in the community. The plan shall be developed by the Emergency Department and the Medical Center Safety Committee. (See Center policy and Professional Staff Bylaws Art. V.3, on disaster privileges.)

VII. GENERAL RULES REGARDING SURGICAL CARE

A. Surgical Specimens

All tissue removed in surgery, except organs and tissue to be transplanted, shall be sent to the Medical Center pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. This authenticated report shall be made a part of the patient's medical record.

List of specimens deemed exempt from routine or mandatory submission to the pathology department:

- Foreskin
- Fingernails
- Toenails
- Teeth
- Parasites
- Eye lens
- Skin or other normal tissue removed during a cosmetic or reconstructive procedure
- Incidentally removed rib
- Orthopedic appliances
- Cartilage from pectus repair
- Dental appliances
- Umbilical and ventral hernia sacs
- Gingival hypertrophy of known cause
- Medical devices such as catheters, gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to patient illness, injury or death
- Therapeutic radioactive sources
- Thymus (incidental) from cardiac surgery
- Accessory bones with no underlying lytic or sclerotic lesions

- Penetrating foreign bodies, such as bullets, are given directly to law enforcement personnel
- Foreign bodies NOT associated with patient's harm/injury
- Tonsils
- Tissues obtained solely for the purpose of research, for which a pathological diagnosis is not needed in order to provide patient care. Such research protocols MUST have been approved by the CCHCS Human Research Protection Program prior to tissue procurement.

List of specimens submitted to pathology exempt from mandatory microscopic examination (with exceptions: specific request by the surgeon and/or at the pathologist's discretion):

- Tonsils (Submission at the Discretion of the Physician)
- Extranumerary digits
- Skin tags
- Foreign bodies NOT accompanied by patient's tissue
- Accessory Bones
- Prosthetic cardiac valves without attached tissues
- Nasal bone and cartilage from rhinoplasty or septoplasty
- Sano shunts
- All devices required for tracking under the Safe Medical Device Act
- Bezoar

List of specimens submitted to the laboratory exempt from cytologic examination (with exceptions: specific requests by the physician or other health care provider):

- Joint space or body cavity effusions with a prior cytologic diagnosis of malignancy or other condition in which drainage is performed for therapeutic measures or symptomatic relief
- Urine, bronchoalveolar lavage or cerebral spinal fluid collected for reasons other than cytologic examination
- Abscess fluid or empyema

B. Cytology Specimens

If adequate material is available, body fluids (for example: CSF, serosal, joint, image guided aspiration or any other fluid expected to contain cells) removed for diagnostic purposes should be submitted for cytopathologic examination, in addition to microbiology and chemical analysis. Fluids removed for therapeutic purposes (for example: decompression/evacuation of serosal fluid) with an existing diagnosis do not need to be sent for cytological examination. Disposal of any body fluid specimen must be documented in the patient's medical record.

C. Verification of Surgical/Invasive Procedure Site

The practitioner who is credentialed to perform a surgical or invasive procedure must be the individual who marks the site of the procedure and shall follow the process required by Cook Children's Medical Center Policy PS 573.

D. Discharge from Recovery Area

The anesthesiologist, surgeon or their designee who is familiar with the patient is responsible for the decision to discharge a patient from the recovery area.

E. Therapeutic Sterilization of a Patient

Surgery which incidentally produces sterilization can be performed on a minor or person who is mentally incompetent only after a consultation has been obtained from an appropriate physician consultant. A procedure, which is primarily for the purpose of sterilization and is not being performed for a medical or health reason, shall not be performed on a minor or a person who is mentally incompetent, without a court order or other judicial review.

VIII. CONTROL OF INFECTION

A. Report of Infections

Infections will be reported in accordance with Medical Center Infection Control policy.

B. Isolation Procedures

Isolation procedures are as follows:

1. The System Infection Control Committee shall develop policies and procedures for the isolation of patients with infectious diseases and for those patients who develop infectious diseases subsequent to admission. This Committee shall have authority to take any appropriate remedial actions.

2. The Attending Practitioner may order isolation of a patient, but an order is not required.

3. If the Attending Practitioner does not order isolation, and in the opinion of nursing personnel, isolation is necessary, the charge nurse or Infection Control Nurse may institute appropriate isolation procedures.

4. It shall be the responsibility of the charge nurse to enter isolation status into the electronic medical record.

5. For additional information the Staff member may reference the Center Infection Control Manual and/or Policy.

IX. HOUSE STAFF

A. Who May Serve as House Staff

The House Staff shall consist of medical graduates who are enrolled in a postgraduate training program which has contracted with the Center or who have arrangements with individual preceptor Staff members and approval from the Chief Medical Officer and the Credentials Committee. House Staff may function within the Medical Center in the context of receiving instruction and training only.

B. Approval Required

Each applicant who shall participate in the House Staff must present such information about his/her qualifications as the Center may from time to time require. The applicant and Staff preceptor shall then present a completed application form to Medical Staff Services for registration as House Staff and approval by the Credentials Committee. House Staff hold

none of the privileges or prerogatives of Staff membership and are not entitled to any procedural rights of review or other appeal procedures.

C. Scope of Activity

1. Medical Graduates, Interns and Residents

Medical graduates, interns and residents may be approved by the Credentials Committee to perform the following in accordance with Medical Center policies: History and physical exams; make rounds (but these shall not replace attending rounds); assist the Staff preceptor in surgery, dictate/write/enter in hospital records and enter orders, however, orders must be countersigned by the Staff member overseeing the medical graduate, intern or resident within twenty-four (24) hours and in accordance with their authorization to practice from the Center. Medical graduates, interns and residents may not perform invasive procedures independently or act as a primary surgeon. Medical residents may take call and admit patients seen in the Emergency Department to the service of the Staff preceptor if such is approved as part of the training program.

2. Orthopedic Residents

Orthopedic residents in the second year of training or above may admit patients seen in the Emergency Department to the service of the orthopedic surgeon on-call. The orthopedic surgeon on-call at the time of the admission is responsible for the care of the patient as the Attending Practitioner, and is responsible for the supervision of the orthopedic resident.

Orthopedic residents may reduce simple fractures and dislocations and may apply circumferential casts and casting materials in the Emergency Department without direct supervision. The orthopedic surgeon on-call at the time of the Emergency Department care is responsible for the follow-up care of the patient, and is responsible for the supervision of the orthopedic resident.

The orthopedic surgeon on-call must respond and assume care of any patient in the Emergency Department if the patient or patient's legal representative refuses to consent to treatment by a resident, or if the resident requests the direct supervision of the orthopedic surgeon.

3. Medical Students

a. Medical Students are not considered House Staff. Active Staff physicians may request observation status for a medical student within their specialty by notifying Medical Staff Services. Authorization must be received from the Chief Medical Officer for each medical student, unless there is a contract with the educational institution in place. The medical student must complete a registration form in Medical Staff Services providing documentation of the following:

(1) Full name and social security number.
(2) Name and proof of enrollment of medical school.
(3) Time frame for requested observation status.
(4) Name of sponsoring Active Staff physician.

b. Observation status consists of observing the sponsoring Staff physician, and may include obtaining a patient history and performing a non-invasive

physical examination. Non-invasive physical examinations may only be performed as requested by the sponsoring Staff physician and if permitted by the parent or legally authorized representative of the patient. A physical examination by a medical student must be performed in the presence of an adult family member of the patient or other adult chaperone.

c. No procedures may be performed by any medical student. The medical student is acting at all times under the supervision of the sponsoring Staff physician, and sponsoring Staff physicians who fail to abide by this guideline may be referred to the Credentials Committee for action.

d. Consent must be obtained from the parent or legally authorized representative of the patient prior to any observation by a medical student or the performance of a history and physical examination by a medical student. The sponsoring Staff physician and the medical student are responsible for ensuring the medical student is properly identified to patients.

e. There shall be a contract between the Center and the educational institution for those medical students who will be in Center for more than twenty (20) hours and/or whose educational facility has had more than two (2) medical students at the Center during a six (6) month period.

f. Medical Students will follow applicable System and Center policies and procedures and all Federal and State statutes, laws, rules and regulations.

4. Termination

Activity may be terminated by the Chief Medical Officer or his/her designee. Termination shall not entitle the House Staff member or any medical student to any procedural rights to review or other appeal procedures.

Signed_____
Chair, Medical Board, for the Professional Staff Date

Signed_____
Chair, Board of Trustees, for the Center Date