# RULES AND REGULATIONS
# OF THE MEDICAL STAFF
# OF
# PETERSON HEALTH
## KERRVILLE, TEXAS

**RULES AND REGULATIONS**
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# RULES AND REGULATIONS OF THE MEDICAL STAFF

# OF PETERSON HEALTH

# KERRVILLE, TEXAS

## A. ADMISSION (to include OBSERVATION) AND DISCHARGE OR TRANSFER OF PATIENTS

1. A patient may be admitted to the Medical Center only by a member of the Active, Courtesy or Advanced Practice Provider staff which has been granted admitting privileges.

2. Dental and podiatric members may admit patients only with the concurrence of an appropriate physician member who shall assume responsibility for the medical aspects of the patient's care throughout the hospital stay. [See Section B.1. for further detail.]

3. The attending provider shall be responsible for the medical care and treatment of each patient in the hospital, for completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring provider. Whenever these responsibilities are transferred to another Staff member, an order covering the transfer of responsibility shall be entered in the order section of the Medical Center medical record.

4. No patient shall be admitted to the Medical Center until a provisional diagnosis for the admission has been stated. All admissions to the ICU or the IMC must be seen by the admitting provider within one (1) hour of admission. All other admissions must be seen by the admitting provider within nine (9) hours of admission. Patients admitted to the ARU must be seen in accordance with Medicare regulations.

5. The admitting provider shall be responsible for giving all information to the Medical Center that may be necessary to enable the protection of other patients and the patient from self-harm.

6. Patients who are planned admissions shall ordinarily be seen in the pre-admission clinic at least 72 hours prior to admission. Where this is not possible, and especially in the case of pre-operative admissions, the attending provider shall arrange for completion of the necessary laboratory work and x-rays on an outpatient basis.

7. The attending provider is required to regularly document in the patient's chart the need for continued hospitalization. This documentation must contain:
    a. Necessity of continued hospitalization;
    b. Treatment plan and anticipated period of time patient will need to remain in the hospital; and
    c. Plans for post hospital care.

8. The patient shall be discharged or transferred only upon order of the attending provider. No patient shall be discharged or transferred without a final diagnosis on the patient's chart. Should a patient leave the Medical Center against the advice of the attending provider or without proper discharge or transfer, a notation of the incident shall be made in the patient's medical record.

9. In the event of a hospital death, the deceased shall be pronounced dead by the attending provider, another privileged member of the Medical Staff or a Registered Nurse in accordance with Medical Center policy.

## B. MEDICAL RECORDS

1. A complete admission history and physical examination should include the history of the present illness, past history, an appropriate review of systems, a physical examination with all pertinent findings resulting from an assessment of all the systems of the body, a list of the patient's medications and any pertinent test results. A statement of impressions or provisional diagnoses and a plan of treatment must also be included in the history and physical examination.

    a. A complete admission history and physical examination shall be dictated and placed in the medical record or entered electronically in the medical record within twenty-four (24) hours of admission and before any surgery or procedure involving anesthesia**,** except in extreme life threatening emergencies.

    b. If a complete history and physical examination has been recorded within thirty (30) days prior to admission it may be used in the medical record as a preliminary history and physical examination report; provided (i) the report was recorded by a member of the Medical Staff, and (ii) an update note is documented at admission and before any surgery or procedure that involves anesthesia that includes any changes or additions to the physical examination or a note that there are no changes in the examination.

    c. The medical history and physical examination must be completed and documented by a physician (defined as: doctor of medicine or osteopathy; doctor of dental surgery or of dental medicine; or doctor of podiatric medicine), oral and maxillofacial surgeon, or other qualified licensed independent provider in accordance with State law and privileged by the Medical Center.

    d. An Advanced Practice Provider may perform the history and physical examination, subject to any physician authentication requirements, if granted the clinical privileges to do so.

    e. The PRMC History and Physical Outpatient Record form or a Progress Note form may be used to document the history and physical examination when a stay of less than forty-eight (48) hours is anticipated.

    f. Any patient who is in the Medical Center and who stays over forty-eight (48) hours, regardless of inpatient or outpatient, will have~~/~~ computerized history and physical examination and discharge summary.

2. An admit note shall be recorded at the time of admission on the progress note sheet if not documented in the Electronic Health Record. This admit note should address the chief complaint, and the pertinent historical, physical and laboratory findings sufficient to define clearly the patient's reason for admission. The admit note should also include the provisional diagnosis on admission and a brief treatment plan.

3. Daily progress notes during admission are required by the attending of record. These notes should address previous abnormal or new clinical problems and correlate physician's orders with results of tests, treatments and outcomes. Both the admit note and daily progress notes should demonstrate continuity of care or (if applicable) transferability to another setting.

4. A note must be entered in the progress notes immediately after surgery or a procedure and before the patient is transferred to the next level of care. The note shall include: procedure(s) performed, description of each procedure finding, estimated blood loss, specimens removed, post-operative diagnosis, any complications, patient condition at the end of the procedure, and names of primary operating provider and assistant(s).

5. Operative or procedure* reports are to be dictated immediately after surgery or a procedure, and contain: a description of the findings, the name and description of procedures performed, the specimens removed, the post-operative diagnosis, and the name(s) of the primary operating provider and assistant(s). All diagnostic and therapeutic procedures are recorded and signed/authenticated in the medical record. (*Procedures that do not involve a description of findings do not require a dictated operative or procedure report.)

6. Consultations shall show evidence of a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's documented opinion and recommendations. A brief written note will be recorded on the chart and a complete consultation dictated or preferably documented in the Electronic Health Record. It is expected that consultants will continue to follow their patients regularly, documenting care rendered and changing recommendations as dictated by changes in clinical status, laboratory or radiographic results and communicating these recommendations with the attending by documentation in the Electronic Health Record.

7. The current obstetrical record shall include a complete prenatal record, when available. This may be a legible copy of the attending provider's office record transferred to the Medical Center before admission.

8. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. Stamped signatures are not acceptable on any medical record. Electronic or facsimiles of original written or electronic signatures are acceptable. Cosignatures must also be timed and dated.

9. A discharge summary shall be completed in the computer or dictated by the attending provider on all patients who are hospitalized over forty-eight (48) hours or who expire. A final discharge progress note may be substituted for a dictated discharge summary on normal obstetrical deliveries, normal newborn infants, and stays less than 48 hrs.

The discharge summary will concisely recapitulate the provisional and final diagnosis, the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, outcome of hospitalization and the condition of the patient on discharge, medications, provisions for follow up care, any specific patient instructions, and disposition of care.

10. Written authorization of the patient (or legally authorized representative) is required for release of medical information to persons not otherwise authorized to receive this information in accordance with Medical Center policy or bylaw.

11. The medical record will contain evidence of informed consent for procedures and treatments in accordance with Medical Center policy.

12. All records are the property of the Medical Center and may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Copies of records may be requested in accordance with Medical Records policy.

13. Access to all medical records shall be afforded to Staff members for study and research approved by the Medical Executive Committee, consistent with preserving the confidentiality of personal information concerning the individual patients and to the extent permitted by law. Subject to the discretion of the CEO and to the extent permitted by law, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

14. A medical record shall not be permanently filed until it is completed by the responsible provider or, if the provider is no longer available, ordered filed by the Quality Monitoring Committee.

15. All initial admitting orders and all clinical outpatient orders shall include the patient’s name, diagnosis or signs and symptoms, date, time, and signature of the ordering provider.

16. The patient's medical record should be completed at the time of discharge. Where this is not possible because final laboratory or other essential reports have not been received, the patient's medical record will be available in Meditech. If the record still remains incomplete after seven (7) days of the date of discharge, the record becomes delinquent. In the event that any Staff member has delinquent hospital records, the following procedures shall be accomplished to obtain the Staff member’s present and future compliance:

    a. On the first Monday following the record becoming delinquent, the Director of Medical Records, CEO or Chief of Staff will notify the Staff member of the delinquency in writing with a record of receipt.

    b. If the delinquency has not been fully corrected by 2:00 p.m. Thursday following the Monday notification, the Staff member’s clinical privileges will be automatically suspended in accordance with ARTICLE VII, Section 6.a. of the Bylaws. The CEO shall notify the member orally, if possible, and send the

member written notice of the suspension by hand delivery or other valid means (email with read receipt, certified mail, or direct verbal conversation). The member will be assisted by the Chief of Staff in the transfer of all of the Staff member's inpatients to other Staff members or in discharging his patients if he so chooses.

c. In case of the Staff member's illness or absence from the city at any time prior to the date of the automatic suspension of clinical privileges, upon the member's notice to the Director of Medical Records of the illness or absence, the member shall be automatically afforded an additional five (5) days, beginning with the date of the member's return from the illness or absence from the city, to complete the incomplete or delinquent medical records. Other extenuating circumstances may be considered by the Chief of Staff.

d. Reinstatement.
   1) At such time as the suspended member has completely corrected his delinquent medical records, the Director of Medical Records shall so notify the Chief of Staff.
   2) The Chief of Staff will then notify the CEO to restore the member's privileges as soon as possible. Multiple suspensions may be a consideration for Corrective Action.

17. Providers shall comply with the approved list of abbreviations, acronyms, symbols, and dose designations that are NOT to be used, which at a minimum include: U, u, IU, qd, QD, QOD, DC, subq, SC, a trailing zero or lack of a leading zero, MS, MSO4, and Mg SO4. Compliance with CPOE will guarantee compliance with this issue.

## C. GENERAL CONDUCT OF CARE

1. A general consent form signed by or on behalf of every patient admitted to the Medical Center must be obtained at the time of admission. The Admitting Office should notify the attending provider whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the provider's obligation to obtain proper consent before the patient is treated in the Medical Center. In addition to obtaining a general consent to treatment, a specific consent shall be obtained by the provider before performing any procedure or treatment set out on List A and B of the Texas Medical Disclosure Panel or, if not listed, that involves any risks or hazards that could influence a reasonable patient in deciding whether or not to consent, in accordance with Medical Center policy. In the case of an emergency precluding obtaining consent, the attending provider shall document the existence of the emergency in the progress notes. See also Section E.15. below.

2. All orders for treatment shall be entered by Computerized Provider Order Entry (CPOE). Telephone/Verbal orders should be limited to situations where CPOE is not feasible and shall be used infrequently. Verbal orders must be signed by the ordering provider within 24 hours. Licensed nurses, pharmacists, and other licensed, registered, or certified personnel from clinical departments are authorized to accept verbal orders. Telephone orders to the nurses units may only be accepted by licensed nurses. All telephone/verbal orders require a "read back". The licensed person receiving the order must read the order back to the provider for confirmation and

document that the read back was accomplished. The order shall be signed by the person to whom it was dictated and shall include the name of the ordering provider, e.g., “S. Jones, RN, per Dr. J. Smith”. All telephone/verbal orders must be e-signed, timed and dated by the ordering provider or another provider who is responsible for the care of the patient within 24 hours.

3. Unless precluded by an emergency, consultation is recommended in the following situations:

   a. When the patient has high risk factors for operation or treatment;
   b. When the diagnosis is obscure after ordinary diagnostic procedures have been completed;
   c. Where there is doubt as to the choice of therapeutic measures to be utilized;
   d. In unusually complicated situations where specific skills of other providers may be beneficial;
   e. In instances in which the patient exhibits severe psychiatric symptoms; and
   f. When requested by the patient or his family if clinically relevant.

   When the patient’s care needs exceed the clinical privileges or expertise of the current attending provider, consultation with an appropriate specialist with the needed privileges will be required. The attending provider will provide authorization to permit another provider to attend or examine his patient, except in an emergency. When deemed appropriate the Chief of Staff, Chief of Service, Chief Medical Officer and/or the Medical Executive Committee may request consultation of another provider(s) without consent of the attending provider. Consultation shall be requested by a provider-to-provider communication and the results communicated back in the same manner. An intensivist consultation is required for all patients admitted to the ICU with a stay for greater than 24 hours.

   Use of restraints (violent or non-violent) shall be in accordance with Medical Center policy. Use of non-violent restraints requires an RN assessment and a call to a physician or provider within one (1) hour to receive a telephone/verbal order. A physician or provider must examine the patient within twenty-four (24) hours of initiation of the restraints and enter an electronic order for the restraints in the medical record. Each order for the use of restraints may not exceed twenty-four (24) hours; violent restraints require frequent renewal depending on age. Use of violent restraints additionally requires the physician or provider complete a face-to-face evaluation within one (1) hours of initiation. If the use of restraints is indicated beyond twenty-four (24) hours, it shall require a separate time-limited order after the ordering physician’s or provider’s examination of the patient. PRN or standing orders for restraints are not permitted. Vital signs and nursing observation of such patients will be at a minimal interval of two (2) hours. When more than seventy-two (72) hours of continuous restraint or more than four (4) episodes occur within a seven (7) day period, the physician or provider should consider meeting with the treatment team and discuss alternatives.

4. In addition to those required by law, Medical Staff members should consider patient autopsies in cases of unusual death, medical-legal interest, or educational interest. An autopsy may be ordered by the attending provider with permission of the patient’s

legally authorized representative; by the Justice of the Peace or other legal authority; or by family request. Autopsies shall be performed by the Medical Center's pathologist or by a provider delegated this responsibility in accordance with Medical Center policy.

5. Hand off communication to a covering provider should include: up to date information regarding the patient's care, treatment and services, conditions and any recent or anticipated changes. This should be an interactive communication that allows for the opportunity for questioning between the giver and receiver of patient information.

6. All Staff members and others with clinical privileges must wear identification issued by the Medical Center at all times when participating in patient care in the Medical Center. This shall not apply to those wearing scrubs where sterile technique is required, e.g., Cath Lab, Operating Room, pre or post operative areas.

## D. MEDICATION MANAGEMENT

1. The provider's orders must be entered electronically by Computerized Provider Order Entry (CPOE). All orders for medications shall include the date and time of the order, the name of the drug, the dosage, the route, frequency of administration, and indication.

2. All drugs and medications administered to patients shall be included in the Medical Center formulary or meet the requirements for the use of non-formulary drugs. All formulary drugs are approved by the Food and Drug Administration for human use. Drugs for clinical investigations may be exceptions. These drugs are administered in full accordance with federal and state regulations and guidelines developed by the appropriate committee.

3. The Pharmacy and Therapeutics Committee develops a system whereby medications are evaluated, appraised and selected such that drugs considered most useful for patient care are stocked within the hospital. Selected drugs will be listed on the Medical Center formulary. The criteria for selecting medications included in the formulary are based on need, efficacy, risk, potential error and cost. Any member of the medical, pharmacy, or nursing staff may petition the committee in writing to review a drug for formulary inclusion. The Pharmacy Department will prepare a review of the available data in collaboration with the requesting physician. The requester will be invited to defend the petition with the committee.

4. When a medication is not on the Medical Center's formulary or not available in the Medical Center pharmacy, a patient may use his/her own medications if specifically authorized in writing by the attending provider. Patients' own medications must be identified by the pharmacist prior to administration to the patient.

5. The pharmacy will procure non-formulary medications for patients when a therapeutic substitution is not acceptable by the prescribing provider.

6. The use of bedside medications is discouraged. In the rare event that bedside medications are deemed absolutely necessary, a provider order to the specific bedside use medication is required. Medications left at the bedside must be administered following the Self-Administration of Medications by Inpatient policy and procedure requirements.
7. Medication automatic stop orders (ASO) are reminders to assess patient medication orders for selected classifications of drugs at specified intervals. In support of antibiotic stewardship and opioid stewardship, an ASO of eight days will be in effect for controlled substances and antibiotics. This will include a 5-day "soft stop" reminder and an 8-day "hard stop". Pharmacy protocols for ASOs may also be put in place based on recommendations from the Pharmacy & Therapeutics committee as dictated by current evidence based medicine practice.

8. All existing orders for patients shall be reviewed and reordered or discontinued when the patient is transferred from one level of care to another or after surgery.

9. If the provider desires a specific medication that the patient has been taking in the Medical Center to be sent home with the patient, he must write or call the order to the Pharmacy. Medications must be properly labeled and dispensed through the Pharmacy before being sent home with the patient.

10. Pharmacy Services department will fill outpatient prescriptions, when necessary, in compliance with federal and state law.

11. Weight-based dosing is required for the pediatric patient whose age limit is from birth to thirteen (13) years of age.

## E. GENERAL RULES REGARDING SURGICAL CARE

1. General procedural authority in the Operating Room shall be vested in the Director of Surgical Services. An appeal from a ruling of the Director of Surgical Services shall be made in writing by a provider to the CEO (or the Chief Medical Officer as his designee).

2. Scheduling:

    a. Emergency operations shall be given priority when necessary and when a delay constitutes a hazard to the patient's condition.

    b. Elective surgery may be done between the hours of 7:30 a.m. and completed by 5:00 p.m. Monday through Friday of each week, except for holidays designated by the Medical Center.

    c. Block scheduling may be utilized and must be requested in writing through the Block Committee.

3. Operations shall be posted in order as scheduled with the earliest surgeon scheduling receiving priority. Changes may be made by general agreement between the operating surgeons and the Operating Room Director.

4. Schedulers will be available between 7:30 a.m. and 5:00 p.m. After 5:00 p.m. and on weekends, notify the Nursing Supervisor if a case must be posted. Minimum information required to make a scheduled appointment for an operation is the patient's name, the operation to be performed, the type of anesthetic requested, and the primary surgeon's name. The name of the assistant surgeon and any special equipment needed may also be recorded and will be helpful to the Operating Room personnel.

5. Minor surgery that is usually performed in the Operating Room and/or requires the involvement of Operating Room personnel is discouraged from being performed in the patient's room, and should be done in the Operating Room or pre-operative area. When the attending provider determines that this would not be in the best interest of the patient because of difficulty in moving the patient or other extenuating circumstances, exceptions may be made by the Director of Surgical Services (or the Nursing Supervisor in the Director's absence).

6. Operating Room techniques shall be standardized by Association of Operating Room Nurses standards.

7. Prior to anesthesia and operation, the patient shall be positively identified in accordance with the Patient Safety Universal Protocol.

8. The medical record shall include:

    a. A pre-operative diagnosis, an adequate initial progress note, and a history and physical examination (in the case of an emergency precluding a complete H&P, the operating provider shall document the existence of the emergency);

    b. Satisfactorily signed consent (see 15. below for further detail); and

    c. Pre-operative laboratory, x-ray and EKG evaluation at the discretion of the surgeon, anesthesiologist or attending provider.

9. Anesthesia documentation requirements.

    a. Except in the case of an emergency precluding the following, which emergency shall be documented by the operating provider, the patient shall have had a pre-anesthesia evaluation documented in the medical record within the 48 hours prior to the procedure to include the following: notation of anesthesia risk; anesthesia, drug and allergy history; planned anesthetic technique; any potential anesthesia problems identified; and patient's condition prior to induction of anesthesia.

    b. The intraoperative anesthesia record shall include: the patient identification; name of the provider administering anesthesia and, as applicable, the name and profession of the supervising anesthesiologist or operating provider; name, dosage, route and time of administration of drugs and anesthesia agents; IV fluids; blood or blood products if applicable; oxygen flow rate; continuous recordings of patient status noting blood pressure, heart and respiration rate; and any complications or problems occurring during anesthesia, including time and description of symptoms, review of affected systems, vital signs, treatments

rendered, and patient's response to treatment. The record shall correlate with the controlled substances record.

c. A post-anesthesia follow up report shall be written by the person administering the anesthesia before transferring the patient from the post-anesthesia care unit and shall include: evaluation for recovery from anesthesia; level of activity; respiration; blood pressure; level of consciousness; and patient's oxygen saturation level.

d. With respect to inpatients, a post-anesthesia evaluation for proper anesthesia recovery shall be performed after transfer from the post-anesthesia care unit and within 48 hours after surgery by the person administering the anesthesia, a registered nurse, or a physician which shall include monitoring/assessment of: 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.

e. With respect to outpatients, immediately prior to discharge, a post-anesthesia evaluation for proper anesthesia recovery shall be performed by the person administering the anesthesia, a registered nurse, or a physician which shall include monitoring/assessment of: 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.

10. Starting time for operations: Surgeons must be in the surgical area and ready to commence operation at the time scheduled and in no case will the Operating Room be held longer than thirty (30) minutes after the time scheduled, except in cases of delay due to an emergency. Efficient utilization of the Operating Room will be the responsibility of the Operating Room Director.

11. The presence of an assistant at surgery will be at the discretion of the primary surgeon unless required by the surgeon's grant of clinical privileges.

12. Tissue removed during the operation shall be sent to the Medical Center pathologist according to the three approved categories of examination of specimens by the pathologist. The first category includes those specimens, which may be exempt from examination, but labeled ID only:

    a. Category I

        1) Specimens that by their nature or condition do not permit fruitful examination such as orthopedic appliances, foreign bodies, cataracts, portions of rib removed to enhance operative exposure, or non-pathological bone fragments or cartilage, and any implantable device being removed from a patient;
        2) Therapeutic radioactive sources;
        3) Traumatically injured members that have been amputated and for which

examination for either medical or legal reasons is not deemed necessary;

4) Foreign bodies (for example, bullets) that for legal reasons are given directly to the chain of custody to law enforcement representatives;
5) Foreskins from the circumcisions of all males, except if appearing abnormal;

6) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;
7) Teeth, provided the number, including fragments, is recorded in the medical record;
8) Hernia sacs, except if appearing abnormal; and
9) Renal and gall bladder stones.

b. Category II - This category includes items not covered in Category I for which the provider submitting the tissue feels only a gross examination is appropriate. Stones (renal and gallbladder) will not be sent for gross examination.

c. Category III - This category includes all tissues not in Category I and II. These tissues will have gross and microscopic examination.

13. Providers and others shall wear appropriate attire in the Operating Room area. In general, this shall consist of an operating room suit, cap, mask and shoe covers.

14. Non-employee observers in the surgical suite. In general, observers are to be discouraged because of the increased demands that observers place upon Operating Room personnel. Personnel in general should be limited to individuals participating in patient care. All visitors must be properly dressed. It is the prerogative of the operating surgeon to designate who may be present in the surgical suite; however, the policy of permitting Medical Center personnel from other departments to observe in surgery is actively discouraged. Agreement for observers should be arranged in advance with the Operating Room Director. Proper authorization will be obtained from the patient for any non-employee observer. All observers must adhere to Medical Center policies and procedures.

15. Written, signed, informed surgical consents shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record by the operating provider. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. All providers shall abide by the policies and procedures as approved by the Medical Center which shall be consistent within the guidelines set forth by the Texas Medical Disclosure Panel.

16. Policy on Use of Flammable Gases for Anesthesia. Flammable anesthetic gases (i.e., cyclopropane, diethylether, ethylene and vinethene) will not be used or stored in the Medical Center. Only non-flammable anesthetic gases (i.e., Fluothane, nitrous oxide, Penthrane and Ethrane) will be used and stored at the Medical Center along with conduction and intravenous anesthetic agents.

## F. GENERAL RULES REGARDING OBSTETRICAL CARE

1. The current standards of American College of Obstetrics and Gynecology will be used as guidelines.

2. Consultation with another qualified physician member shall be required for therapeutic abortions.

3. The attending provider shall have the responsibility and authority to regulate the presence of persons in the labor and delivery room with his patients subject to Medical Center policy.

4. A qualified medical provider (QMP) for purposes of affording a medical screening examination for an emergency medical condition in accordance with Medical Center policy in the Women's Health Center is defined as follows:

    a. A Registered Nurse (RN) with a minimum of two (2) years of labor and delivery experience who has completed an annual competency in fetal monitor interpretation and is competent in the screening protocols established by the Obstetrics and Gynecology Section as set forth below.

    b. Each Women's Health Center nurse serving as a QMP will annually demonstrate competence in fetal monitoring and the screening protocols established by the Obstetrics and Gynecology Section. The Women's Health Nurse Manager and the Medical Director of OB/GYN must certify in writing which nurses are competent to be a QMP.

    c. The screening protocols will be annually reviewed, revised if necessary, and approved by the OB/GYN Medical Director.

5. All providers responsible for the care of the child shall be certified in the Neonatal Resuscitation Program (NRP).

## G. EMERGENCY SERVICES

1. The on-call rotation for the Emergency Department will be prepared by each specialty and submitted to the Medical Center operator, and shall be subject to the approval of the Medical Executive Committee and the Board of Directors. In addition to complying with paging policies, the provider on-call must be able to arrive in the Emergency Department within sixty (60) minutes of a request to do so by the Emergency Department physician.

    a. The schedules will be for at least a one-week period of time and are due no later than the Wednesday prior to the effective week. Any changes to the schedule after submitted must be called in to the operator or placed in QGenda, the

facility's online scheduling software.

b. A member of a specialty with fewer than three (3) providers shall submit an on-call schedule of at least ten (10) days per month for each provider, which do not overlap.

c. If a patient presents to the ED in need of that specialty and no one is on-call in that specialty, the patient may be transferred to assure proper treatment in accordance with Medical Center policy.

d. Emergency call will be optional after Staff providers have practiced at the Medical Center for a period of ten (10) years and attain age sixty (60). They may continue on on-call rotation if they indicate a desire to do so to the Chief of Staff.

e. Whenever the call schedule is not received in the time frame indicated in 1.a. the Chief of Staff will notify the Staff member of the delinquency. If the delinquency has not been corrected by the time the schedule is to go into effect, the Staff member's clinical privileges will be automatically suspended on the first weekday of the schedule in accordance with ARTICLE VII. Section 6.~~a.~~A.of the Bylaws. The CEO shall notify the member verbally, if possible, and send the member written notice of the suspension by hand delivery. This suspension will be in effect until the Staff member has submitted a call schedule. Privileges will be restored as soon as possible after the call schedule has been received. Multiple suspensions may be a consideration for Corrective Action. Extenuating circumstances may be considered by the Chief of Staff.

f. Response to pages: If a provider does not respond, the operator will page a second time. If the provider doesn't respond to the second page, the operator will try the backup number given (home or spouse). No response to three attempts will initiate calls to others in the same specialty and possibly law enforcement.

g. Delayed or non response to call are serious issues that could compromise patient care and/or potentially initiate an EMTALA infraction and fine. The first call issue for a provider will be documented with a letter of reprimand. If a second occurrence is reported, the provider will be asked to appear before the Medical Executive Committee.

2. An appropriate medical record shall be kept for every patient receiving emergency service.

3. There shall be a written emergency management plan for the care of mass casualties at the time of any major disaster. The plan should be rehearsed periodically, preferably as part of a coordinated drill involving community emergency service agencies and key personnel. The Medical Staff members shall be informed of their responsibility and may participate in the planning and evaluating of drills.

4. A qualified medical provider (QMP) for purposes of affording a medical screening examination for an emergency medical condition in accordance with Medical Center policy in the Emergency Department is defined as follows:

a. A Nurse Provider (NP) credentialed by the Medial Staff and Board of Directors to work under the sponsorship of the Emergency Department physicians.

b. A Physician's Assistant (PA) credentialed by the Medical Staff and Board of Directors to work under the sponsorship of the Emergency Department physicians.
c. A Texas OAG (Office of Attorney General) certified SANE (Sexual Assault Nurse Examiner) may do a medical screening exam on sexual assault victims that have no other injury.

The NP and PA, under written protocol, will be authorized to conduct a medical screening examination.

5. Emergency Department providers may write "Bridge Orders" to expedite the process of moving patients being admitted into the hospital, rather than waiting for the Admitting Physician to write Admission Orders. The bridge order set will be comprised of:
   a. Admit to Dr. _____
   b. Bed Type:
   c. Diagnosis:
   d. Condition:

## H. APPROVED LABORATORIES AND OTHER DIAGNOSTIC TESTS

1. All clinical laboratory tests performed on inpatients will be performed at the Medical Center Clinical Laboratory or its designated reference laboratory(ies).

   a. An acceptable reference laboratory is one that is:

      1) Accredited by the College of American Pathologists, and
      2) Recommended by the director of the pathology and clinical laboratory services, and
      3) Approved by a majority vote of the Medical Executive Committee.

   b. Clinical laboratory tests obtained on outpatients or on inpatients prior to their admission to the Medical Center may be accepted as meeting requirements outlined in these Rules and Regulations, may be used for diagnostic and therapeutic purposes and will be made a part of the patient's permanent record at the discretion of the attending provider if the laboratory is accredited by the College of American Pathologists.

   c. Other Diagnostic Tests (such as X-Ray, EKGs, Pulmonary Function Test, etc.) obtained on out-patients or on inpatients prior to their admission to the Medical Center may be accepted as meeting requirements outlined in these Rules and Regulations, may be used for diagnostic and therapeutic purposes and will be made a part of the patient's permanent record at the discretion of the attending provider if an interpretation is obtained by the attending provider from an appropriately credentialed member of the Medical Staff.

## I. NEWBORN CARE

The standards of care for newborns at the Medical Center shall be as follows:

1. Attendance at Delivery: A pediatrician is not required for births in which no problems are anticipated. The obstetrician may request a physician to be present if felt indicated.
2. Physical Examination: A physical examination should be performed on all newborns. In the healthy newborn, with no problems during pregnancy, labor or delivery, the examination shall be written or dictated and shall be done within eighteen (18) hours of delivery.

3. Daily Rounds: A daily nursery visit shall be made with written documentation of the patient's condition and problems in the progress notes.

4. Discharge Physical Examination: A physical examination should be performed at the time of discharge as indicated by the patient's condition. At the time of discharge, the attending provider should discuss routine newborn care with the parent or parents with instructions for home care and follow-up visits.

## J. SUPERVISION OF MEDICAL STUDENTS AND RESIDENTS

1. Physicians accepting medical students or residents for preceptorship programs ("sponsoring provider") must submit the preceptor form and copies of correspondence received from the Medical School or Residency Program to the Medical Staff Services (MSS) department at least one (1) month prior to the student or resident's expected arrival.

    a. Upon arrival the student/resident must report to MSS for registration and a computer orientation. The student/resident must wear approved identification at all times when in the Medical Center.

    b. Patients will be informed in advance by the sponsoring provider when a student/resident is participating in their care. The patient's oral consent to the participation of the student/resident must be documented in the medical record by the attending provider.

2. First and second year medical students may observe and review only. They may not perform procedures or document in the medical record. Third and fourth year medical students will not perform any task or function without a supervising provider being either physically present or immediately available to provide guidance. Students may not perform daily rounds in lieu of the attending or consulting provider.

3. Residents may not perform procedures without the immediate availability of a supervising provider.

4. All entries (notes and orders) in the medical record by students must be countersigned by the attending or supervising provider within 48 hours of the entry and prior to implementation of the order. For residents, entries and orders must be countersigned by the attending or supervising provider within 48 hours.

## K. SUPERVISION OF ADVANCED PRACTICE PROVIDER STUDENTS

1. Physician members serving as preceptors or sponsoring physicians of a mid-level provider serving as preceptors for Advanced Practice Provider students must submit the preceptor form and appropriate documentation from the educational program to the Medical Staff Services (MSS) department at least one (1) month prior to the student 's expected arrival.

    a. Upon arrival at the Medical Center, the student must report to MSS for registration and a computer orientation. The student must wear hospital approved identification at all times when in the Medical Center.

    b. Patients will be informed in advance by the attending provider when a student is participating in their care. The patient's oral consent to the participation of the student must be documented in the medical record by the attending provider.

2. An Advanced Practice Provider student may accompany their preceptor in the Medical Center. The sponsoring physician or a credentialed Advanced Practice Provider also supervised by the sponsoring physician must always be present or immediately available. Unless otherwise provided below, the sponsoring physician or the Advanced Practice Provider must cosign all notes within 24 hours and all orders prior to their implementation. The permissible scope of practice shall include:

    a. Observe and assist sponsoring physician, including assisting in surgery when the sponsoring physician is physically present;

    b. Perform H & Ps subject to review and cosignature within 24 hours of the patient’s admission;

    c. Perform medical screening examinations subject to review and cosignature prior to patient discharge from the Emergency Department; and

    d. Document in the patient’s medical record.

Students may not perform daily rounds in lieu of the attending or consulting provider.

## L. WAIVED TESTING

Waived Tests are those diagnostic laboratory tests classified as waived under federal law and regulatory agencies. At the Medical Center, all waived tests are used in the diagnosis and care of the patient and will be considered definitive testing.

## M. PSYCHIATRIC OR SUBSTANCE ABUSE PATIENTS

Patients with acute primary psychiatric diagnoses or substance abuse problem(s) will not be admitted to the Medical Center except for the provision of stabilization treatment for emergency medical conditions within the capacity and capability of the Medical Center in accordance with Medical Center policy. Appropriate psychiatric consultation and/or transfer to appropriate psychiatric hospital or substance rehabilitation center will be obtained as soon

as the patient is medically stable and consultation can be reasonably obtained. Patients who develop acute psychiatric problems or acute withdrawal and detoxification problems while in the Medical Center will be treated by the same criteria as above.

## N. REPORTS TO HOSPITAL'S ACCREDITING AGENCY

Providers are encouraged to participate in the internal processes set up to report and resolve concerns about patient safety and quality issues. Any provider who has unresolved concerns about the safety or quality of care provided at this facility may report these concerns to the hospital's accrediting agency. No retaliatory disciplinary action will be taken because of a report to the hospital's accrediting agency.

## O. INTENT STATEMENT

Policies and procedures are intended to assist the provider in the optimal delivery of health care and to enable the provider to deliver health care in compliance with federal, state, and local laws and regulations. It is expected that each provider will comply with the policies and procedures of the Medical Staff and of the Medical Center. Policies and procedures that set out health care delivery guidelines are not intended to establish medical or nursing standards of care, the variation from which necessarily implies negligence or substandard care. If there are circumstances which warrant a variation or deviation from the stated policy or procedure, the provider should document those circumstances in the medical record.