OVENANT HOSPITAL PLAINVIEW

Medical Staff Rules and Regulations

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the hospital only by a Member of the Medical Staff. All Providers shall be governed by the official admitting policy of the hospital.

2. A Member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient. All patients shall have a complete history and physical performed and recorded in the medical record by a provider who is either a Member of the Medical Staff or has been approved by the Medical Staff to do so or by another individual with such privilege based on demonstrated competence. Dentists and Podiatrists shall be responsible for recording in the medical record a history and physical examination relative to the dental history and physical examination relative to the dental or podiatric problem. Any medical problem present on admission or arising during the hospitalization of a dental or podiatric patient shall become the responsibility of a qualified provider. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The format of the discharge summary requirements to complete the patient record shall be determined by the decision of the Executive Committee upon recommendation of the Medical Records Committee.

3. Each Provider must assure timely, adequate professional care for his patients in the hospital by being available or having available, through his office, an eligible alternate Provider with whom prior arrangements have been made and who has privileges at the hospital. A provider who is attending a patient receiving care in the hospital, and who will be out of the area, shall make arrangements to assure appropriate continuing care of that patient.

4. The Attending Provider is required to document. This documentation must contain the diagnosis, treatment and plan of care.

   Upon request of the Medical Executive Committee, the Attending Provider must provide written justification of the necessity for continued hospitalization of any patient hospitalized thirty (30) days or in excess of Parameter Limitations of Disease, including an estimate of the number of additional days of stay and the reason therefore. Tis report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action. Any patient remaining in the hospital over two (2) months must have the stay approved by the Medical Executive Committee and the Chief Executive Officer.

5. Patients shall be discharged only on order of the Attending Provider. Should a patient leave the hospital against the advice of the Attending Provider, or without proper discharge, a notation of the incident shall be made in the patient’s medical record and where possible, proper release forms signed.

6. Admitting Provider shall:
    a. Refer elective cases to the Admitting Office for advance arrangements.
    b. Complete records required to secure payments of insurance or compensation claims by the hospital.
    c. Record information required for hospital billing.
    d. Adhere to hospital admitting policies and procedures.

7. In the event of a hospital death, the deceased shall be pronounced dead by the Attending Provider or his designee within a reasonable time. Policies, with respect to release of dead bodies, shall conform to local law.

8. It shall be the duty of all Staff Members to attempt to secure permission to perform autopsies in all cases of unusual deaths and of medical-legal interest.

B. MEDICAL RECORDS

1. The Attending Provider shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations; clinical laboratory and radiology services and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge notes; clinical resume; and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within twenty-four (24) hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission to the hospital, a reasonable, durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and reports are recorded by a Member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within twenty-four (24) hours of admission.

3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the Attending Provider states in writing that such delay would be detrimental to the patient.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. 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 results of tests and treatment. Progress notes shall be written at least daily on all patients, except patient under Swing Bed Status.

5. Operative reports, or other high-risk procedure reports, shall include the following information: name of the LIP who performed the procedure and his/her assistant (if applicable), name of the procedure performed, description of the procedure performed, finding of the procedure, estimated blood loss, specimens removed, and the postoperative diagnosis. Operative reports shall be written (or dictated) immediately following surgery for both out-patients and in-patients, and the report will be promptly signed by the Surgeon and made a part of the patient's current medical record. When a full operative or other high-risk

procedure report cannot be entered in the patient's medical record immediately after the operation or procedure, a progress note will be entered into the medical record before transferring the patient to the next level of care. This progress note shall include: the name of the primary surgeon and his/her assistant (if applicable); procedure performed, description of each procedure finding, estimated blood loss, specimens removed and postoperative diagnosis.

6. A pre-anesthesia evaluation of the patient, done within 48 hours before surgery or a procedure requiring anesthesia service, will be documented in the medical record and in all elective surgery cases prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This evaluation will include reference to the choice of anesthesia (general, spinal, other regional, or standby), the patient's previous drug history, other anesthesia experiences, and any potential anesthetic problems. It is required that the patient's physical status be categorized using the classification of the American Society of Anesthesiologists.

7. The anesthesia provider will do a pre-assessment of the patient and equipment. They shall record in the medical record all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood and blood components.

8. At least one (1) post-anesthesia visit must be made within 48 hours after surgery or procedure requiring anesthesia service, at which time a dated and timed note is to be made in the medical record describing the presence or absence of anesthesia-related complications. Patients who undergo surgery under local anesthesia or monitored anesthesia care, who are awake and alert upon dismissal from the operating room are exempt from this requirement.

9. Medical record information from a post-anesthesia recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area; the vital signs; and, when such are in use, the status of infusions, surgical dressings, tubes, catheters and drains.

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

11. The current obstetrical record shall include a complete prenatal record, when available. The prenatal record may be a legible copy of the Attending Provider's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

12. All entries in the medical record shall be accurately dated, timed and authenticated.

13. A discharge note will be recorded at the time of discharge.

14. A discharge clinical summary shall be written or dictated on inpatient medical records. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate. The clinical resume should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed

and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, as pertinent. Consideration shall be given to instructions relating to physical activity, medication, diet and follow-up care.

15. All records are the property of the hospital. In case of readmission of a patient, all previous records shall be available for the use of the Attending Provider. This shall apply whether the patient is attended by the same Provider or by another. Unauthorized removal of charts from the hospital is grounds for suspension.

16. Members of the medical staff are considered Business Associates of the hospital.

17. A medical record shall not be permanently filed until it is completed by the responsible Provider or is ordered filed by the Medical Executive Committee.

18. The patient's medical record shall be complete at time of discharge, including progress notes, final diagnosis and clinical summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated location in the medical record room for thirty (30) days after discharge. If the record still remains incomplete thirty (30) days after all essential reports have been received and placed on the record the Chief Executive Officer shall notify the Provider by Certified receipted mail that his/her privileges to admit patients shall be suspended until records are completed. The Admitting Office shall be notified of this action. Three (3) such suspensions of admitting privileges within any twelve (12) month period shall be sufficient cause for permanent suspension of the privileges of the hospital for that Provider.

19. No signature stamps shall be used by providers or their agents.

20. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:
    a. Adequate patient identification;
    b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
    c. Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the hospital;
    d. Description of significant clinical, laboratory and roentgenologic findings;
    e. Diagnosis;
    f. Treatment given;
    g. Condition of patient on discharge or transfer, and
    h. Final disposition, including instructions given to the patient, and/or his family, relative to necessary follow-up care.

21. The Radiology Service shall provide authenticated reports for all radiologic examinations performed in the hospital and, when requested, for review of examinations performed outside the hospital. In either case, this will provide the official report for the medical record.

    Otherwise the Attending Provider may record his/her interpretation in the history or progress note section of the medical record. When special radiologic procedures can be properly interpreted only with the findings and observations of the provider performing the procedure,

this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.

22. Providers requesting diagnostic examinations by the Pathologist or Radiologist must provide in the written request all relevant information available to help assure an accurate diagnosis/impression and proper use of resources.

23. If an error is made on an entry in the medical record, a single line shall be drawn through it, and the correct entry written in along with the date and authentication of the Provider. The error is not to be obliterated or erased, but will be identified as an error.

24. Medical Records submitted for a provider's review as part of the peer review process will be completed within four (4) weeks. If the record has not been completed within this period of time, the Chief Executive Officer will notify the provider of the intent to restrict his or her admitting privileges as outlined in No. 20.

C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The Admitting Clerk shall 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 at the hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure should be obtained. Appropriate forms for such consents should be adopted with the advice of legal counsel.

2. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to duly authorized person functioning within his/her sphere of competence and signed by the responsible Provider (or appropriate member of the House Staff). All orders dictated over the telephone shall be signed by the Provider per his or her own name. The responsible Provider shall authenticate such orders within 24 hours, and failure to do so shall be brought to the attention of the appropriate peer review committee for appropriate action.

   Licensed or registered personnel are only authorized to accept verbal orders in their area of specialty. The following is a list of licensed/registered personnel to accept verbal orders:
   a. Registered Nurse
   b. Licensed Vocational Nurse
   c. Registered Pharmacist
   d. Registered/Licensed Dietitian
   e. Licensed Social Worker
   f. Licensed Chemical Dependency Counselor
   g. Physician Assistant
   h. Licensed Physical Therapist
   i. Registered Occupational Therapist
   j. Licensed Physical Therapy Assistant
   k. Registered Radiologic Technologist
   l. Licensed Respiratory Care Practitioner
   m. Medical Technologist/Medical Laboratory Technician

3. The Provider's order must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4. All previous orders are canceled when patients go to surgery or change level of care.

5. A method for control of drugs brought into the hospital by patients must be established.

6. The medical staff will maintain a policy regarding the automatic stop orders for medications.

7. Self-medication by patients will be permitted if the provider deems necessary and assumes full responsibility on a written order.

8. All Providers shall participate in patient discharge planning in accordance with the Utilization Review Plan.

9. All Providers shall comply with requirements of the hospital's Occurrence Screening and Risk Management Program.

10. The Attending Provider is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another Attending Provider to attend or examine his patient except in an emergency. The consult will be completed and recorded or direct contact with requesting provider will be within twenty-four (24) hours unless exception is made by the requesting physician.

11. If a Nurse has any reason to doubt or question the care provided to any patient and, after discussion with the attending provider, believes that appropriate consultation is needed and has not been obtained, he/she shall call this matter to the attention of his/her supervisor who in turn may refer the matter to the Director of Nursing Service. If warranted, the Director of Nursing Service may bring the matter to the attention of the President or designee. Where circumstances are such as to justify such action, the President, after consultation with the Hospital Administrator, may bring this to the attention of the Medical Executive Committee for investigation, review, and action.

12. If a written and signed complaint is filed with the Hospital Administrator or President of the medical staff regarding a provider's personal conduct or professional services, the medical staff policy on Code of Conduct will be followed.

13. The Executive Committee, through the Chairman or Provider Members and the hospital Infection Control Coordinator, has the authority to institute any appropriate control measures or studies when it is reasonable felt that danger to patients, visitors or personnel exists. This includes placing a patient in isolation precautions even though the Attending Provider or designee will be notified prior to Executive Committee action.

14. Radiographs and pathology slides are property of the hospital and may be lent to other hospitals. Providers or research institutes for valid reasons and only with the permission of the patient and the Attending Provider.

15. All in-patients and observations patients shall be visited by their Attending Provider or his or her designee with appropriate privileges at least once every twenty-four (24) hours and this shall be documented in the medical record. If an absence of more than twenty-four (24) hours is contemplated, the Attending Provider shall arrange with another qualified member of the Medical Staff to attend to his/her patients, and the Nursing Staff shall be notified as to who will be responsible in the interim.

16. A member of the Medical Staff may request to be placed on the panel for electrocardiography interpretation, echocardiography interpretation, or Holter monitor interpretation if the provider has been granted privileges for these interpretations.

D. GENERAL RULES REGARDING SURGICAL CARE

1. A patient admitted for dental care is a dual responsibility involving the Dentist and the Provider Member of the Medical Staff.
   a. Dentist's Responsibilities
      (1) A detailed dental history justifying hospital admission;
      (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis;
      (3) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the Dentist shall clearly state the number of teeth and fragments shall be sent to a Pathologist for examination;
      (4) Progress notes as are pertinent to the oral condition;
      (5) Clinical resume (or summary statement).
   b. Provider's Responsibilities:
      (1) Medical history pertinent to the patient's general health;
      (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;
      (3) Supervision of the patient's general health status while hospitalized;
      (4) A Provider Member of the Medical Staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of dental patients.
   c. The discharge of the patient is on written order of the Provider Member of the Medical Staff and agreement of the Dental Member.

2. A patient admitted for podiatric care is a dual responsibility involving the Podiatrist and the Provider Member of the Medical Staff. (If admitted to Hospital Staff.)
   a. Podiatrist's Responsibilities (if admitted to Hospital Staff):
      (1) A detailed podiatric history justifying hospital admission;
      (2) A detailed description of the examination of the feet and a preoperative diagnosis.
      (3) A complete operative report describing the findings and technique. Specimens shall be sent to a Pathologist for examination.
      (4) Progress notes as are pertinent to the foot condition;
      (5) Clinical resume (or summary statement.)
   b. Provider's Responsibilities:
      (1) Medical History pertinent to the patient's generalized health.
      (2) A provider examination to determine the patient's condition prior to anesthesia

c. The discharge of the patient shall be on written order of the Provider Member of the Medical Staff and agreement of the Podiatrist Member.

3. Written, signed, informed surgical consent 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 from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

4. Ordinarily all tissue removed at the time of surgery shall be sent to the hospital pathologist for examination and the removal will be documented. The limited categories of specimens that may be exempted from the requirement to be examined by the pathologist are:
   a. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
   b. Therapeutic radioactive source, the removal of which shall be guided by radiation safety monitoring requirements;
   c. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
   d. Specimens known to rarely, if ever, show pathologic change, and circumcision of a newborn infant;
   e. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;
   f. Teeth, provided the anatomic name or anatomic number of each tooth, or fragment of a tooth, is recorded in the medical record.
   g. Ptyergium specimens.

5. The surgeon is to be in the operating area prior to the administration of anesthesia.

6. Same Day Surgery
   a. Any Ambulatory (Same-Day) Surgery who has received other than local or topical anesthesia shall be examined by a provider prior to the time of discharge or meet established discharge criteria.
   b. Provider performing surgical procedures shall report any post-discharge infections to the Infection Control Surveillance individual.

E. <u>GENERAL RULES REGARDING ANESTHESIA SERVICES</u>

1. Anesthesia will be provided by a medical staff provider or certified registered nurse anesthetist (CRNA) according to the provisions of the Texas Medical Practice Act and regulation promulgated thereunder.

2. Provider shall order anesthesia by written or signed written confirmation of a prior verbal order. Pursuant to a provider's order, an anesthesiologist or CRNA may select, obtain, and administer those drugs and apply the medical devices appropriate to accomplish the order and maintain the patient within a sound physiological status.

3. An informed consent from the patient is obtained prior to anesthesia administration which includes documentation of the need for, risks of, and anesthesia options (if any).

4. A pre-anesthesia assessment will be performed and documented in the medical record. The assessment will include:
    a. Evidence of a patient interview verifying past and present medical and drug history and previous anesthesia experience(s);
    b. Evidence of a patient physical status assessment; it is recommended the physical status assessment be categorized using the classification of the American Society of Anesthesiologists.
    c. Results of relevant diagnostic studies; and
    d. Plan (choice of anesthesia).

5. After the pre-anesthesia assessment and before the administration of anesthesia, a staff provider or CRNA with appropriate clinical privileges shall review the pre-anesthesia assessment results to determine if the patient is a candidate for the planned choice of anesthesia.

6. The patient's physiological status is measured and assessed during the operative or invasive procedure. The level of monitoring is dependent on the patient's preoperative status, anesthesia choice, and the complexity of the operative or invasive procedure.

7. At least one (1) post-anesthesia visit must be made within 48 hours after surgery or procedure requiring anesthesia service, at which time a dated and timed note is to be made in the medical record describing the presence or absence of anesthesia-related complications. Patients who undergo surgery under local anesthesia or monitored anesthesia care, who are awake and alert upon dismissal from the operating room are exempt from the requirement. Patients may be discharged through the use of established discharge criteria.

8. Anesthesia personnel or, if not available, the attending provider, will discharge from the Post Anesthesia Care Unit. The patient will be released from the PACU when discharge criteria has been met and/or an order of the anesthesia personnel or attending provider is given.

F. <u>EMERGENCY SERVICES</u>

1. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Service Area. This shall be in accordance with the hospital's basic plan for the delivery of such services, including the delineation of clinical privilege for all providers who render emergency care.

2. The MEC can assign providers on the Active Staff and Associate Staff (with the exception of podiatrists, dentists, and Active Staff members of any specialty age 70 years or older who have requested release from Emergency Room Coverage) to take Emergency Room specialty call on a rotating basis with the other specialty members. Single member specialty providers will provide specialty care on an available basis. Availability will be monitored by the MEC; and

3. If, at any time, the Hospital does not have arrangements for Emergency Department Coverage, providers on the Active Staff (with the exception of podiatrists, dentists, and Active Staff members of any specialty age 70 years or older who have requested release from Emergency Room Coverage) clinically treating patients, shall provide Emergency Room

coverage on a rotating basis with the other Active Staff members. If necessary to insure adequate Emergency Department specialty coverage, the MEC may assign members of the Medical Staff to a specialty call section based on privileges requested and granted to a member.

4. A provider contacted by the Emergency Department for a consultation will respond in a timely fashion. Response will either be in person or through a telephone conversation with the ED provider.

5. The ER Provider's responsibility ends when the ED Provider turns medical attention of the patient over to the Attending Provider.

G. HOSPITAL RESTRAINT POLICY

Providers will apply the use of restraints under the guidelines of the current hospital policy and procedures which will be in compliance with regulatory standards.

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