Grace Medical Center

MEDICAL STAFF

RULES & REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder.

ARTICLE I
ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

1.1(a) Excluding emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership. All practitioners shall be governed by the admitting policy of the hospital. Physician assignment of patients within services shall be on a rotational basis.

1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.

1.1(d) Emergency Department Physicians shall be required to maintain documentation regarding current ACLS certification.

1.1(e) Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients (including patients under the care of participants in the professional graduate education program), for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient any referring practitioner and to relatives of the patient where appropriate. Whenever those responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, the following should be contacted, in order of priority listed below:

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The Chief of Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

1.2. ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Within twenty-four (24) hours following all admissions, the Attending Physician shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) Preoperative Admissions

This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.

1.2(c) Routine Admissions

This will include elective admissions involving all services.

1.3 PATIENT TRANSFERS

1.3(a) Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;

(2) From any department to ICU in an emergency;

(3) From ICU in an emergency;

(4) From temporary placement in an inappropriate area to the appropriate area for that patient.

1.3(b) No patient will be transferred between departments without an order by the Attending Physician.

1.3(c) If the Intensive care unit is full and a patient requires ICU care; all physicians attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination, and shall make the decision.

1.4 SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a) A patient suspected to be suicidal in intent shall be admitted to a security room consistent with the patients medical needs. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded psychiatric consultation;

1.4(b) The hospital social worker should be consulted for assistance; and

1.4(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except that the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the Hospital's EMTALA policy, that the benefits of transfer outweigh the risks.

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.5(a) Patients shall be discharged only on order of the Attending Physician. Should a patient leave the hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge process shall provide for continuing care based on the patient's assessed needs at the time of discharge.

1.5(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.

1.5(c) The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefor. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

1.5(d) The Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and hospital staff shall ensure that the patient is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patient's transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge; and

(4) The anticipated need for continued care following discharge.

1.6 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the Attending Physician, another member of the Medical Staff, the Emergency Department Physician or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient's medical record.

1.7 AUTOPSIES

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants.

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician (or other licensed independent practitioner credentialed to perform a history and physical) within twenty-four (24) hours of admission. A history and physical performed by a physician assistant or nurse practitioner must be signed by that individual and then authenticated and countersigned within twenty-four (24) hours, or prior to the patient undergoing surgery, by the attending physician. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Failure to dictate/write the patient's history and physical within twenty-four (24) hours after admission shall result in the physician being notified that he/she will have twenty-four (24) hours in which to complete the history and physical. Following this, if the history and physical remains delinquent, physician may be suspended until the H&P is complete. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

A history and physical performed within thirty (30) days prior to hospital admissions may be used, as long as the medical record contains durable, legible practitioner documentation indicating:

The history and physical has been reviewed and is still current;

That an appropriate assessment was completed within 24 hours after inpatient admission or prior to surgery, whichever comes first, confirming that the necessity for the procedure or care is still present; and

That the patient's condition has not changed since the history and physical was originally completed.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded within twenty-four (24) hours prior to all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not in the chart of every patient before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patient's health.

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. Members of the medical staff, Clinical dieticians, pharmacists, licensed therapists and AHP's, credentialed or employed as identified in Article VII of these Rules & Regulations, may make entries into the progress notes pertinent to their areas.

2.5 OPERATIVE/PROCEDURAL REPORTS/ORDERS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written immediately following surgery, and the report made a part of the patient's current medical record prior to patient leaving recovery room or before leaving the OR if patient is being transferred directly to ICU. Appropriate post operative and/or discharge orders are required prior to the patient leaving PACU or the Endoscopy suites. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note must include the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation

note shall be recorded prior to the operation, except in emergency situations so verified on the record.

2.7 CLINICAL ENTRIES/AUTHENTICATION

All entries in the patient's medical record shall be accurately dated, authenticated and timed. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key

2.8 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEC and filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure. A list of abbreviations 'not' to be used is on all physician orders and posted in all clinical areas. This list of not-to-be-used abbreviations is obtained from published sources of the Joint Commission.

2.9 FINAL DIAGNOSIS

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible practitioner at the time of discharge of all patients.

2.10 REMOVAL OF MEDICAL RECORDS

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.11 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

Any physician on the Medical Staff may request a release of patient information providing that said patient is under his/her care and treatment. Such release will not require a Release of Information form to be signed by the patient when release of such information is necessary to provide continuity of care to the patient, and the treatment for which the physician seeks release of information was provided by the physician in question, at his/her request or direction, or by or at the direction of another physician who provided such treatment in

consultation with such physician.

Persons not otherwise authorized to receive medical information shall require written consent of the patient, his/her guardian, his/her agent or his/her heirs.

Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.12 PERMANENTLY FILED MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the MEC, the Chief of Staff or CEO with an explanation of why it was not completed by the responsible practitioner(s).

2.13 STANDING ORDERS

In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed annually by the physician and the Utilization Review Committee. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

2.14 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.15 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every fourteen (14) days. At the twenty-first (21st) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at thirty (30) days and the physician's privileges will be suspended if any records become delinquent.

2.15(a) Suspension. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible physician's privileges. When a staff member is notified of suspension, the staff member may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are

completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the Chief of Staff and the CEO.

2.15(b) The suspended staff member is obligated to provide to the hospital CEO and the Chief of Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that physician provides.

2.15(c) All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

2.15(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO, or the chairperson of the Quality Management Committee, or equivalent Medical Staff committee.

2.16 TREATMENT & CARE WRITTEN ORDERS

Orders for treatment and care of patients may not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician.
Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations. Only graduates of an accredited medical school may write orders and only under the direction of the preceptor physician. Medication orders and invasive procedures must be countersigned by a medical staff member.

2.17 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".

To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, write the word 'error', enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.18 JOINT COMMISION REQUIREMENTS

2.18(a) Safety Standards. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting

reports of the condition of the patient any referring practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

2.18(b) Unanticipated Outcomes. In the event of an unanticipated outcome or adverse event, the patients' treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital's Policy on Disclosure of Treatment Outcomes.

ARTICLE III
GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

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 patient business office should notify the Attending Physician whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing. Verbal orders are discouraged except in emergency situations and shall be used infrequently as required by Texas State Regulations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. or L.V.N. and signed by the R.N. or L.V.N and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNA's may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The responsible physician shall authenticate and date any order as soon as possible, such as during the next patient visit as required by Texas State Regulations, and in no case longer than forty-eight (48) hours after the order is written. Failure to do so shall be brought to the attention of the MEC for appropriate action. All medication orders shall be authenticated by the prescribing practitioner as soon as possible, such as on the next patient visit, but in no case longer than forty-eight (48) hours after the order is written. Orders for outpatient tests require documentation of a diagnosis for which test is necessary. When orders are authenticated, they must be signed, dated and timed.

Verbal orders will generally not be accepted for chemotherapy drug orders, investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. Telephone orders for chemotherapy, investigational drug, device or procedure protocols and Do Not Resuscitate orders may be given over the telephone only with two (2) nurses witnessing the order(s). Withdrawing of life support will only be implemented with an order written and authenticated by the prescribing practitioner, AND in accordance with applicable hospital policies regarding advanced directives.

3.3 ILLEGIBLE TREATMENT ORDERS

The practitioner's orders 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.

3.4 PREVIOUS ORDERS

All previous orders are canceled when patients go to surgery.

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.

3.6 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from the hospital pharmacy. When the patient brings medication to the Hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of orders to continue individual medications. Blanket reinstatement orders, i.e "resume" all medications orders, are banned. Medications must be individually addressed in orders.

3.7 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. If not resolved, the Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

3.8 PATIENT CARE ROUNDS

Hospitalized patients shall be seen at least daily and more frequently if their status warrants. Patients admitted to Intensive Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than eight (8) hours after admission or sooner if warranted by the patient's condition.

3.9 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.10 RESPIRATORY THERAPY ORDERS

The duration of orders for respiratory therapy concerning ultrasonic nebulization, incentive spirometry, postural drainage and percussion will be discontinued after three (3) days unless otherwise ordered. All other ultrasonic nebulization, incentive spirometry postural drainage and percussion will be discontinued after five (5) days unless otherwise ordered, but not without notification to the Attending Physician.

3.11 PATIENT RESTRAINT ORDERS

The MEC will approve all patient restraint policies and procedures prior to implementation and all Medical Staff members will abide with all hospital policies pertaining to restraints and seclusion. This policy applies to all patients of Grace Medical Center, based on the assessment of patient's needs and federal regulations.

3.12 EMERGENCY SERVICES STAFF

Each Medical Staff member who staffs the emergency room shall be required to hold current ACLS certification.

3.13 PRACTITIONERS ORDERING TREATMENT

Licensure will be verified for all practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner's Medical Staff status or lack thereof.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

Excluding emergencies, prior to any surgical procedure, a history, physical and other appropriate information including the preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record. If not recorded, the operation shall be canceled. In all emergencies, the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

4.2 ADMISSION OF DENTAL CARE PATIENT

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

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

(1) To provide a detailed dental history justifying hospital admission;

(2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis;

(3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the hospital pathologist for examination;

(4) To provide progress notes as are pertinent to the oral condition; and

(5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

(1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery;

(2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the Attending Physician.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

(1) To provide a detailed podiatric history justifying hospital admission in conjunction with a licensed MD/DO of the medical staff;

(2) To provide a detailed description of the podiatric findings and a preoperative diagnosis;

(3) To complete an operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination;

(4) To provide progress notes as are pertinent to the podiatric condition; and

(5) To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician, or Licensed Independent Practitioner credentialed to provide admission History and Physical, are:

(1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;

(2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

4.4 SURGICAL CONSENT

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high risk treatments (as provided by hospital policy and/or state law) 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. The consent form shall be signed by the patient only after the risks and benefits of the procedure, alternative treatment methods and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician. After informed consent has been obtained and documented by the surgeon, the nurse shall obtain the patient's signature on the consent form and shall witness the signature. In those 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. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

4.5 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in writing.

4.6 ELECTIVE SURGERY SCHEDULING

In order to reduce patient anxiety resulting from a long wait, reduce staff overtime for elective work and allow time for possible emergencies, the following guidelines will be used for scheduling elective surgeries. Emergency procedures shall take priority above all other cases.

4.6(a) Standing Time:

7:30 a.m.

4.6(b) Priority Cases shall include:

(1) Age 12 and under;

(2) Open bone work;

(3) Latex allergic patients; and

(4) Contaminated cases last, if possible.

4.6(c) Scheduling of Cases:

(1) It is recommended that elective surgery be scheduled by 3:00 p.m the previous day;

(2) All cases must be scheduled with Operating Room Staff and/or House supervisor;

(3) All cases must be taken in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-existing priority cases;

(4) If a scheduled case is canceled, the schedule will be moved up to fill the vacancy. New cases will not replace the canceled case. Any other case scheduled by the same surgeon will be added to the end of the schedule.

(5) If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified and consent to the change; and

(6) The start time for a surgery shall be deemed to be the time of incision or invasion. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will then follow other scheduled cases. If the surgeon is more than fifteen (15) minutes late, the OR Supervisor will attempt to contact the surgeon and ascertain when he/she will be available. If the surgeon will not be available within a reasonable period of time, the next scheduled surgery shall commence and the case will be moved to the end of the schedule.

4.6(d) Preoperative workup is as deemed appropriate by the surgeon or anesthesiologist.

4.7 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the responsible licensed physician.

4.8 ANESTHESIA

The anesthetist or anesthesiologist shall maintain a complete anesthesia record including evidence of pre-anesthesia evaluation used to determine whether the patient is an appropriate candidate for the planned anesthesia. Also included in the record shall be a pre-induction evaluation and a post-anesthesia follow-up of the patient's condition by the anesthetist upon admission to and discharge from the post-anesthesia recovery area**.** Patients admitted shall have another post-anesthesia visit within 24 hours of surgery.

Responsibility for the overall management of anesthesia lies with the Director of Anesthesia. Anesthesia includes general, regional and conscious sedation given in the OR, delivery rooms, Emergency Department, or any other location within the hospital where such services are administered and during special procedures (imaging) or endoscopy.

The anesthetist or anesthesiologist will be available to perform consultation relating to respiratory care and invasive monitoring line placements upon request of Medical Staff members.

The anesthetist or anesthesiologist will be responsible to obtain and document informed consent for anesthesia in the medical record. Only qualified individuals as defined in the policies and procedures of the hospital may provide moderate or deep sedation or anesthesia. The Department of Surgery shall approve credentialing guidelines consistent with Joint Commission standards for individuals providing moderate or deep sedation or anesthesia.

The anesthetist or anesthesiologist will review and document the patient’s condition immediately prior to induction.

In order to ascertain the patient’s wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient/next of kin/agent by the anesthetist or anesthesiologist or the Attending Physician prior to surgery. If the patient’s wishes have changed, documentation signed by the patient/next of kin/agent and Anesthetist or physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the CRNA and/or anesthesiologist must not exceed twenty (20) minutes.

4.9 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement agency and tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement after obtaining appropriate consent.

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

4.10 STERILIZATION PROCEDURES

Sterilization procedures may be performed in conformity with Texas Law & regulations, Federal law & regulations and applicable court decisions. Sterilization's can be performed legally for either therapeutic or non-therapeutic purposes, subject to the usual requisites of informed consent.

4.11 UNIVERSAL PROTOCOL

Universal Protocol for time-out procedures will be followed per Joint Commission standards.

ARTICLE V
EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

5.1 SCREENING, TREATMENT & TRANSFER

5.1(a) Screening:

(1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

(2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician, or Physician Assistant or Advanced Practice Nurse, pursuant to hospital policy, Medicare and other applicable federal regulations.

(4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

5.1(b) Stabilization:

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

(2) 'Stabilization' is achieved when no material deterioration is likely to result from the transfer or discharge of the individual, or, in the case of a pregnant woman having contractions, when the woman has delivered (including the placenta).

(3) A patient does not have to be stabilized when:

(i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or

(ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.

(4) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

5.1(c) Transfer:

(1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3) Upon transfer, the Emergency Department shall provide appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

5.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

5.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall have the right to request the services of his/her physician. This request will be documented in the patient's medical record.

5.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.

5.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the physician in the hospital;

(2) Called the physician at home;

(3) Called the physician at his/her office; and

(4) Called once on the physician's pager.

Twenty minutes will be considered a reasonable time to carry out this procedure in non-emergent situations.

5.2(d) The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may not refuse to respond. Any such refusal shall be reported to the CEO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

When on the Emergency Department 'on call' roster, a physician shall provide coverage in the field of his expertise when called upon by the emergency room physician. In the event of his absence due to a change in schedule, or a professional or personal conflict, the 'on call" physician shall arrange alternate coverage for the Emergency Department. However, an 'on call' physician shall not be held responsible for Emergency Department coverage, or back-up coverage, in the event he is unavailable because he is engaged in surgery, rendering emergency medical care at this or another institution, or if he cannot respond because of situations beyond his control. When the conflicting surgical or emergency medical condition has been resolved and the 'on call' physician once again becomes available, he shall resume his Emergency Department obligations. In this setting, the work emergency shall mean: a medical condition which required immediate attention to relive acute pain and suffering, lessen morbidity, or postpone death.

In the event the 'on call' physician cannot be available for a period of time beyond which is acceptable to the Emergency Department physician, back-up coverage shall be sought by the Emergency Department physician. On occasion, transfer to another medical facility may be appropriate.

5.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility shall include follow-up care of the referred patient in the physician's office. If the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

5.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department.

Physicians called are required to respond to Emergency Department call by telephone

within ten (10) minutes. If requested to come in, they will make every attempt to do so within twenty (20) minutes after responding by telephone.

ARTICLE VI
ALLIED HEALTH PROFESSIONALS

6.1 CATEGORIES & BASIC CRITERIA

Categories and basic minimum criteria for each of the AHP categories can be found in the following subsections. Applicants must meet the established criteria for the category for which they are applying. No individual will be accepted as an AHP unless he/she meets the basic criteria.

6.1(a) Specified Professional Personnel

(1) Physician Assistant: Documented verification of having met the criteria of Physician's Assistants as defined by the Texas State Medical Board.

(2) Advanced Practice Nurse: Documented verification of having met the criteria of Advanced Practice Nurse as defined by the Texas State Board of Nursing.

(3) Speech Pathologist: Documented verification of a M.A. degree in Speech Pathology or certification by the American Speech/Language Association; and A current Texas license.

(4) Clinical Psychologist: Documented verification of graduation from an accredited doctorate program in psychology; Documented verification of certification by the Texas Board of Examiners of Psychologists; and if operating an independent practice, the Clinical Psychologist must have documented of licensure for independent practice in the state of Texas.

(5) Radiation Physicists: College degree in physics and Documented verification of certification by the American Board of Radiology-Radiotherapy Physics.

(6) Echocardiography Technician: Documented verification of registry with the American Registry of Diagnostic Medical Sonographers or actively seeking registry; and CPR certified.

(7) Exercise Test Technologist: Documented verification of certification by the American College of Sports Medicine.

(8) Certified Registered Nurse Anesthetist (CRNA): Documented verification of certification of American Association of Nurse Anesthetists; and Current Texas licensure.

(9) Other Qualifications for All Categories: Letter of recommendation from at least two (2) references who know of the applicant's professional experience and competence; and Documented evidence of continuing education relative to the applicant's area of specialty during the past two (2) years.

6.1 (b) Specified Health Personnel

(1) Physician's Nurse Assistant: Current Texas license.

(2) Scrub Nurse: Completion of Operating Room technician course or certification of qualification by the attending surgeon; and Current Texas license.

(3) Operating Room Technicians: Completion of Operating Room Technician course or certification of qualifications by the attending surgeon.

6.2 FUNCTIONS, DUTIES & RESPONSIBILITIES BY CATEGORY

Each AHP Shall:

(a) Retain appropriate responsibility within the scope of his/her license or certificate and within his/her area of professional competence for the care and supervision of each patient in the hospital for whom he/she is providing services.

(b) Participate in monitoring, review ad evaluation of the quality and appropriateness of patient care; in supervision of initial appointees of his/her same occupation or profession, or a lesser included occupation or profession. And in discharging such other functions as may be required from time to time. The supervisor physician or dentist of his/her responsibilities as delineated in section 5.3.

(c) Abide by hospital policies and procedures.

6.3 The functions, duties and responsibilities for each AHP shall be met as delineated below. They shall not exceed these functions, duties or responsibilities.

6.3(a) Physician Assistant: Granting of privileges shall be in the name of the individual certified Physicians' Assistant and may only work under the auspices of the member of the Medical Staff. His/her conduct and permitted tasks while in this Hospital shall conform to those rules and regulations as stated by the Texas State Medical Board. Privileges desired by the applicant must be requested specifically by the applicant and will be considered and granted or denied by the Credentials/MEC acting on each specific applicant individually and specifically.

6.3(b) Advanced Practice Nurse: Granting of privileges shall be in the name of the individual Advanced Practice Nurse, and may only work under the auspices of the member of the Medical Staff. His/her conduct and permitted tasks while in this Hospital shall conform to those rules and regulations as stated by the Texas State Board of Nursing. Privileges desired by the applicant must be requested specifically by the applicant and will be considered and granted or denied by the Credentials/MEC acting on each specific applicant individually and specifically.

6.3(c) Clinical Psychologist: May act as agents of their supervising Physician to perform diagnostic evaluations (including psychological testing administration) and assist with counseling therapy.

6.3 (c) Speech Pathologist: May consult on speech and language disorder and perform services to include diagnostic communication assessment and subsequent therapy. May not independently solicit patients.

6.3(d) Radiation Physicist: Calibration, repair and safety aspect of radiation producing machines and radioactive sources, dosimeter on machines as applied to patient treatment, development of new techniques, specifications and acquisition of new equipment, computer applications and teaching at all levels.

6.3 (e) Echocardiography Technician: May perform echocardiographic studies under the supervision of a Physician.

6.3 (f) Exercise Test Technologies: May perform graded exercise testing and assist in program development under Physician supervision on patients undergoing recuperative, rehabilitative or preventive regimens.

6.3 (g) Certified Registered Nurse Anesthetist (CRNA): Provide general anesthesia under the overall direction of the Director of Anesthesia Services. Meet such other requirements as set out in the Rules and Regulations.

6.3 (h) Physician's Nurse Assistant: Perform specified patient care services under the supervision, direction of his/her supervising Physicians, consistent with the practice privileges granted to the Nurse Assistant licensure.

ARTICLE VII

SUPERVISION OF MEDICAL STUDENTS, RESIDENTS AND FELLOWS

7.1 MEDICAL STUDENTS, RESIDENTS AND FELLOWS.

7.1(a) Written description of the roles, responsibilities, and patient care activities must be defined as part of the University Affiliation Agreement between Grace Medical Center and the University, and must be consistent with the professional licensure requirements in Texas.

7.1(b) The written description described in Section 7.1(a) must include identification of the mechanism by which the supervisor and school program director will make decisions about participant's involvement and independence in specific patient care activities. In addition, the Affiliation Agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a Medical Students, Resident or Fellow.

7.1(c) Medical Students, Residents and Fellows may write patient care orders and progress notes. The supervising licensed independent practitioner shall review the activities of the Medical Student, Resident and/or Fellow.

7.1(d) There shall be effective communication between the school, the Medical Staff and Grace Medical Center's Board of Managers. The University Affiliation Agreement shall require that the University's Graduation Medical Education Committee provide regular reports, or otherwise communicate with the Medical Staff and the Board of Managers regarding the safety, quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in the professional graduate education program.

ARTICLE VIII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

8.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to bring before the Board formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

8.2 ADOPTION, AMENDMENT & REVIEWS

The Medical Staff Rules & Regulations may be adopted, amended or replaced by a majority vote of Medical Staff members at any meeting where a majority of those eligible to vote are present. At least five (5) days written notice, accompanied by the proposed Rules & Regulations, must be given of the intention to take such action. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

8.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

8.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, and Chairperson of the Board of Trustees; or

8.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board of Trustees.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.

8.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 8.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff

has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well being of patients, employees or staff.

MEDICAL STAFF RULES & REGULATIONS
APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____ _____
Chief of Staff Date

BOARD OF MANAGERS:

By: _____ _____
Chairman Date

GRACE MEDICAL CENTER

By: _____ _____
Chief Executive Officer Date