



# General Medical Staff Rules, Regulations, and Policies

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## ARTICLE I - GENERAL RULES OF CONDUCT OF MEDICAL STAFF MEMBERS

### 1.1. RESPONSIBILITY TO PATIENTS

A Licensed Independent Practitioner (LIP) of the Medical Staff shall be responsible for the medical care and treatment of their respective patients 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, if appropriate, to the Referring Practitioner.

Patients may be admitted to the Hospital only on the orders of a physician (MD/DO), podiatrist, dentist or oral surgeon. All Hospital patients must be under the care of a member of the Medical Staff or under the care of a practitioner who shall be directly under the supervision of a member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a practitioner who meets the Medical Staff criteria and procedures for the privileges granted, who shall have been granted privileges in accordance with those criteria by the Board of Trustees, and who shall be working within the scope of those granted privileges. Patients admitted by licensed independent practitioners who are not physicians (i.e. Dentists or Podiatrists), shall be under the care of a physician with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner.

1.1.1. Attending LIP's Responsibility (Attending LIP is defined as the individual Practitioner who is primarily responsible for directing, coordinating, and managing the medical care of a particular patient):

1.1.1.1. Each member of the Staff who is the Attending LIP of record is ultimately responsible for the emergent, urgent, and non-emergent care of his/her patients. Emergent care is defined as care of patients whose condition is manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's life or limb in serious jeopardy. Urgent care is defined as care of patients whose symptoms indicate a condition that requires prompt medical attention, but who will not generally suffer loss of life or limb if such attention is delayed for a short period of time in a controlled medical environment. Non-emergent care is defined as care of patient whose condition requires attention within twenty-four (24) hours.

1.1.1.2. The Attending LIP is expected to visit his or her patient at least once daily or every 24 hours and document each visit. In the event that the Attending LIP cannot be available, he/she shall have another member of the Staff designated as an alternate to be called to attend his/her patients until the Attending LIP can be present. In case the alternate is not available, the Chief Executive Officer or the Chief of Staff shall have the authority to call the on-call LIP or any other member of the staff to attend the patient. Failure of a member of the staff to meet these requirements may result in disciplinary action.

1.1.2. Responsibility for Emergency Coverage

Members of the Staff shall accept responsibility for emergency care as follows:

1.1.2.1. LIP Evaluation

The patient's emergency medical condition shall be evaluated promptly by a Licensed Independent Practitioner or representative thereof.

1.1.2.2. Services of On-Call Licensed Independent Practitioners

1.1.2.2.1. As required by federal law, this hospital will maintain a list of Licensed Independent Practitioners who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.. The Emergency LIP or treating LIP, in consultation with the on-call practitioner, shall determine whether the patient's condition requires the on-call practitioner to come to the hospital immediately. The determination of the Emergency LIP or treating LIP shall be controlling in this regard. The on-call practitioner must be promptly available within 30 minutes of the request. If the on-call LIP is on simultaneous call at another facility and is unable to respond, the on-call LIP shall provide the name of the back-up LIP who must also have privileges at South Austin Hospital. If a back-up LIP is not provided, 1.1.2.2.2 will be followed. If there is no LIP on-call within the area of expertise required by the patient's condition, the Emergency LIP shall transfer the patient to the closest appropriate facility in compliance with policy.

1.1.2.2.2. If the On-Call LIP fails or refuses to respond in a timely manner, the Emergency LIP will immediately notify the Department Chairperson over the On-Call LIP. If not available, his or her designee shall be notified.

In the event that neither of the above LIPs can be contacted, the following list of officers are to be contacted in descending order:

Chief of Medical Staff  
Vice-Chief of Medical Staff  
Secretary of Medical Staff

1.1.2.2.3. The roster of LIPs on call shall be coordinated with individual departments and approved by individual Department Chairpersons or representatives.

1.1.2.2.4. All required call rosters for the hospital and emergency department must be received in the medical staff office by the 25<sup>TH</sup> of every month for the following month to allow for timely preparation and distribution. Rosters must have the name of the LIP assigned to each slot, not the name of a call group. Any open slots on a schedule that does not have a pre-assigned LIP will be filled by rotating the names of the LIPs responsible for taking call.

1.1.3. Obtaining Consent

1.1.3.1. General Consent to Treatment

A general consent form, signed by or on behalf of every patient provided treatment by the hospital must be obtained at the time of admission. The hospital staff will assist the LIP in obtaining a consent for treatment for each

procedure on the 'List A' required by the State of Texas. The LIP is responsible for informing the patient of the risks, benefits, and alternatives for each procedure. The LIP will document in the patient's medical record that consent has been obtained.

#### 1.1.3.2. Treatment or Procedure Consent

1.1.3.2.1. Written and signed informed consent shall be obtained prior to any procedure defined by the Texas Medical Disclosure Panel as requiring full disclosure and consent of the patient except in those situations wherein the patient's life is in jeopardy and suitable consent cannot be obtained due to the condition of the patient. The Practitioner performing the procedure or administering the medical treatment at issue is responsible for advising the patient or the patient's surrogate decision-maker about the risks, benefits, and alternatives of the recommended treatment or procedure, and for answering any questions that may be asked so that an informed decision can be made. This informative encounter must be documented in the medical records.

1.1.3.2.2. Proper informed consent includes enough information for the patient or the surrogate decision-maker to understand:

- the nature of the treatment/procedure to be performed
- the risks and benefits of the recommended treatment/procedure
- alternatives to the recommended treatment/procedure, including remaining untreated.
- potential problems related to recuperation
- the likelihood of success of the treatment/procedure as well as the possible results of non-treatment.
- Information about potential problems related to recuperation.
- The Practitioner is responsible for documenting in the patient's medical record that the informed consent was obtained including the recommended treatment or procedure, its risks, benefits, and alternative treatments.

1.1.3.2.3. The Practitioner may delegate responsibility for obtaining signatures on the informed consent form to another health care worker; however, responsibility for obtaining an informed consent remains with the LIP performing the procedure or administering the treatment.

1.1.3.2.4. Consent should be obtained as soon as possible, either upon the patient's arrival at the hospital, or when either the procedure or treatment is recommended. It must be obtained before the procedure and/or treatment is performed (especially before any pre-operative medications, sedatives, tranquilizers, or narcotics have been administered).

#### 1.1.3.3. Telephone Consent

Consent by telephone should only be utilized when absolutely necessary. The Practitioner providing the treatment/procedure will obtain the informed consent by telephone using a transcribed document (preferably the hospital's "Disclosure and Consent for Medical and Surgical Procedures" form) with two signed witnesses and followed by a confirmatory letter or facsimile transmission of oral consent.

1.1.3.4. Emergency (Implied) Consent

1.1.3.4.1. Informed consent is implied in emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on patient's medical record. A consultation in such instances may be desirable before the emergency procedure is undertaken (if time permits).

1.1.4. Orders

1.1.4.1. Definitions (Ref Hospital Policy, Process for Approval of Forms and Orders that are Part of the Permanent Medical Record, ):

**Routine (Pre-printed Orders/Order Sets):** are specific to an LIP or group of LIPs and are initiated by an LIP on an individual patient basis, with individualized treatment choices.

**Standing Orders:** are instituted in emergent situations and other clinical situations in which care should be initiated prior to consulting with the LIP, for all patients meeting defined criteria. They are to be used when a delay in treatment caused by waiting for LIP orders would place the patient at risk.

1.1.4.2. All orders for treatment shall be in writing. An order shall be considered to be provisionally "in writing" if dictated to licensed medical personnel (e.g. PA, LVN, RN, pharmacist, physical therapist, respiratory therapist, social worker, dietitian, case manager, occupational therapist, or speech therapist) functioning in their respective spheres of competence and authenticated in a timely fashion. These dictated provisional "in writing" orders will be classified as "verbal" orders until authenticated by the issuing Licensed Independent Practitioner. According to CMS Conditions of Participation regulations, verbal orders, when used, should be used infrequently (§482.23(c)(2)(iii)). It is recognized that there are instances when the ordering physician may be unable to authenticate his/her verbal or preprinted order. In this instance, it is acceptable for the covering physician to sign the verbal or preprinted order for the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. It is not, however, acceptable to allow covering physicians to authenticate verbal or preprinted orders for convenience or to make this common practice.

1.1.4.3. All LIP-directed verbal orders for treatment shall be recorded in the Medical Record in writing and shall be signed and dated by the authorized receiving person within their scope of professional activities. The authorized receiving person to whom the verbal order is dictated must write down the complete order in the appropriate area of the medical record and then repeat what was written back to the LIP to confirm that it was understood and transcribed correctly.

Verbal orders for potent drip, AND (Allow Natural Death) Modified code, drugs, and biologicals shall be authenticated on their next visit by the individual who ordered the medication. All other verbal orders must be authenticated within thirty (30) days post-discharge, except for the instance of physical restraint. Verbal orders will not be accepted for chemotherapy orders but may be accepted by fax. Please see 1.1.4.10 for rules on restraint orders.

1.1.4.4. Orders which are illegible or improperly written will not be carried out until re-written or understood by the Nurse. The Nurse will call that Practitioner to clarify the orders. Repeated illegibility will be brought to the attention of the LIP and corrective action may ensue.

1.1.4.5. The LIP will use MEC approved abbreviations ([ref IM-010](#)) and will not use the following inappropriate abbreviations ([ref IM-186](#)) (either in upper or lower case) for any entry into the medical record: U, IU, qd, qod, MS, ug, dc (or d/c) or cc. The LIP will not use a trailing zero when entering numerals (eg: 1.0 cannot be used; use 1). A leading zero cannot be omitted (eg: .1 cannot be used; use 0.1)

1.1.4.6. All orders are automatically canceled and need to be reordered when the following change in level of care occurs:

- Patient goes to the delivery room
- Patient goes to surgery
- Patient transferred to or from ICU or CVRU

1.1.4.7. The following cannot be prescribed using a verbal order:

- IV Chemotherapy for malignancy

1.1.4.8. Standing and Routine Orders

1.1.4.8.1. Standing orders may be used only in circumstances where patient care is required in a serious or emergent situation in which the LIP is not readily available to provide orders. They are individualized for each specific patient situation. Standing orders shall be instituted only after approval of the Executive Committee of the Medical Staff. Such standing orders must be signed and dated by the responsible Practitioner when utilized as required for all orders for treatment. All standing orders will be reviewed by appropriate Medical Staff on an annual basis.

1.1.4.8.2. Routine orders are defined as those orders used by LIPs where similar routine care is provided to a group of patients; they are not personalized for an individual patient (eg: post-partum, pre-surgical, etc.) A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

1.1.4.8.3. Nursing staff may initiate a physician's routine pre-operative orders, appropriate to the scheduled procedure, without a prior order; the physician will sign and date the order as soon as s/he

arrives. Routine Obstetrical and Pediatric department-approved newborn admission or post-partum orders may be initiated by nursing in the absence of a patient-specific order; the physician will sign and date the order as soon as possible.

1.1.4.9. Smoking Orders

Any exceptions to the hospital smoking policy for patients shall be by a LIP's written order and in compliance with hospital policy.

1.1.4.10. Restraint Orders

A Licensed Independent Practitioner's timed and dated order is required for any type of restraint as per hospital policy, PC-010, Restraints and Patient Safety Guidelines. In an emergent situation, when a patient's behavior becomes a threat to himself or others, restraints may be applied in accordance with current hospital policy.

1.1.4.11. Non-Compliance

If the LIP is deemed by the MEC to be out of compliance, the MEC will take the corrective action deemed most appropriate in the situation.

1.1.5. Consultations

Consultations shall show evidence of a review of the patient's record by the Consultant, pertinent findings on examination of the patient, the Consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative/invasive procedures are involved, the Consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation.

The Attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified Consultant.

1.1.5.1. Mandatory Consultations

Consultations shall be held, except in extreme emergencies, under the following conditions:

- Interruption of pregnancy: All curettage or other procedures by which a known or suspected normal pregnancy may be interrupted. Note: A negative pregnancy test will be considered a consultation.
- When the Attending LIP does not have the clinical privileges needed or necessary for appropriate care of a patient.

1.1.5.2. Recommended Consultations:

- When the patient is not a good medical or operative risk;

- When the diagnosis is obscure;
- When there is doubt as to the best therapeutic measures to use;
- When there is a question of criminal action
- Psychiatric conditions: Psychiatric consultation and treatment will be considered on the following patients:
  - Patients who have recently attempted suicide or suicidal tendencies
  - Patients who exhibit signs and symptoms of substance abuse
  - Patients who have a history of or are exhibiting signs and symptoms of severe depression, severe personality disorder, and/or psychoses.

1.1.5.3. In the event that a Consultant is not available to see the patient, appropriate referral to outside sources of mental health will be performed either during the admission or upon discharge.

1.1.5.4. When a consultation is recommended by the Attending but refused by patient/family, the fact that consultative services were recommended must be documented in the patient's medical record. The patient has the right to refuse consultation.

## **1.2. TRANSFER OF RESPONSIBILITY OF PATIENT(S)**

When and wherever the Medical Staff Member's responsibilities to a patient or patients are transferred to another Practitioner, a note covering the transfer of responsibility shall be entered on the order sheet or the progress note of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the Practitioner transferring his responsibility shall personally notify the other Practitioner to ensure the acceptance of that responsibility is clearly understood.

## **1.3. PRIVACY PRACTICES**

Each practitioner or Allied Health Professional (collectively herein referred to as the "Provider" in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. §164.501, (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Practitioners or Allied Health Professionals.

## **1.4. RESPONSIBILITY TO OTHER HEALTHCARE WORKERS**

Each practitioner and provider is expected to foster a climate of patient safety throughout the organization. Professional and cordial behavior facilitates patient safety and is expected at all times. Behavior to the contrary may be considered disruptive and will be subject to corrective action procedures as outlined in the medical staff bylaws.

## **2. ARTICLE II - MEDICAL STAFF MEMBERS' RESPONSIBILITY IN THE PROVISION OF CARE**

### **2.1. ADMISSION**

#### 2.1.1. General Admissions

- 2.1.1.1. Only Practitioners with Active and Courtesy Staff memberships may admit patients to South Austin Hospital, including inpatients, outpatients and ED service, except as specifically provided in the Medical Staff Bylaws or elsewhere in these Bylaws. Only Practitioners granted clinical privileges may admit, treat, or consult patients in the hospital. All Practitioners with authority to admit patients shall be governed by the admissions policy of the hospital. Dentists and podiatrists with admitting authority must obtain an LIP to perform an admitting history and physical examination for the patient being admitted. Any routine admission testing required by Medicare will be performed.
- 2.1.1.2. The patient shall be assigned to the service of his primary admitting LIP concerned in the treatment of the disease which necessitated admission. In the case of a patient requiring admission who does not have a Practitioner, he shall be assigned to the Practitioner On-Call for the service to which the illness of the patient indicates assignment.
- 2.1.1.3. Except in the case of emergency admission, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible. A copy of the emergency service record shall accompany the patient to the nursing unit.
- 2.1.1.4. The Body responsible for Utilization Review functions (the Medical Care Evaluation Committee) shall review admissions that do not meet the established criteria for the above categories if there is a need to do so. Unjustified variations and recommended actions shall be reported to the MEC for appropriate action.
- 2.1.1.5. If an LIP with consulting privileges is providing short-term coverage for a LIP with admitting privileges, he may admit patients to the LIP for whom he/she is covering, providing these would be patient care responsibilities that would befall the LIP being covered and the covering LIP has the required privileges. This includes covering Emergency Department Call. When such a patient is admitted to South Austin Hospital and the name of the attending LIP is different from the Admitting LIP, both names shall be listed on the admitting sheet.
- 2.1.1.6. Upon admission, the LIP will order the diet appropriate for the patient's age and condition.

## 2.1.2. Emergency Admissions

- 2.1.2.1. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the Practitioner shall, when possible, first contact the Admitting Office or, if closed, the House Supervisor to ascertain if there is a bed available.
- 2.1.2.2. Practitioners admitting emergency cases shall be prepared to justify to the MEC and the administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patients chart as soon as possible but no later than 24 hours after admission.
- 2.1.2.3. After a patient has been evaluated by the emergency department LIP and is believed to require further treatment, the emergency LIP will contact the patient's private LIP for referral. If the patient has no LIP, he or she will be referred to the on-call LIP in the service relating to the patient's problem. It is the On-Call LIP's responsibility to assume care for the patient while in the hospital. The On-Call LIP must be physically in attendance within a reasonable time period after notification by the ED LIP. Patients determined unstable by the emergency LIP shall be seen by the on-call LIP as stated in 1.1.2.2.

## 2.1.3. Intensive or Special Care Units Admissions

- 2.1.3.1. If any questions as to the validity of admission to any Intensive or Special Care Units should arise, the decision is to be made through consultation with the Chief of Staff or his designee.
- 2.1.3.2. Admission to the Intensive Care/Cardiac Care Unit shall be based on the level of patient care required rather than on specific clinical diagnosis. The patient must be critically ill or unstable and in need of intensive treatment and monitoring that cannot be provided outside of the critical care setting. Such treatment includes ventilatory support, hemodynamic monitoring, etc.
- 2.1.3.3. Several models may be used for assessing severity of illness and prognosis of the critically ill patient. These models, in conjunction with clinical judgment, represent the best methods available to determine benefit of admission to critical care units. Examples of these, with prioritization used in triage situations when the number of potential patients exceeds available beds, can be found in current hospital policy, [CC-017](#).
- 2.1.3.4. Patients who are transferred into Intensive Care/Cardiac Care Units from another Nursing Unit are to have, in a timely manner, a note concerning admission to the ICU/CCU written by the LIP.
- 2.1.3.5. The status of patients in critical care units is continuously reviewed to identify patients who may no longer need intensive care. When the patient's physiologic status has stabilized and no longer requires intensive monitoring, or has deteriorated and active interventions are no longer planned, discharge to a lower level of care is appropriate. On discharge, all orders are required to be rewritten.

- 2.1.3.6. If any questions as to the appropriateness of admission to, or discharge from critical care units should arise, that decision is to be made through consultation with the Chief of Staff or his designee.

## **2.2. DISCHARGE**

Patients shall be discharged from the Hospital only on the order of the patient's Attending Practitioner or his designee. Practitioners shall make necessary arrangements in order for all discharge orders to be written to allow patients to be discharged from the Hospital in the morning. This procedure is to facilitate the patient flow for the LIP in the Hospital. Discharge Summaries must be complete in the medical record within 30 days of discharge.

### **2.2.1. Emergency Transfer/Discharge**

Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility, when in the judgment of the Attending LIP, the patient's condition permits such a transfer. LIPs on the call schedule must justify in writing or by telephone to the ED LIP, any transfer of a patient to another hospital on the basis of lack of appropriate services at SAH or because of a family request. Such transfers will be reviewed monthly by the appropriate body with authority for review of hospital utilization.

### **2.2.2. Discharge from Intensive or Special Care Units**

If any questions as to the validity of discharge from any Intensive or Special Care Units should arise, that decision is to be made through consultation with the Chief of Staff or his designee.

## **2.3. TREATMENTS/PROCEDURES**

### **2.3.1. Pharmaceuticals and therapeutics**

#### **2.3.1.1. General**

All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

#### **2.3.1.2. Stop Order**

Unless ordered for a specific time period, orders will continue until discontinued by the LIP or as specified by MEC-approved hospital policy.

#### **2.3.1.3. Home Medications**

Medications brought into the Hospital by a patient may not be used.

2.3.1.4. Acceptable Medication Orders

It is not acceptable to write blanket medication orders such as “continue home meds” or “continue previous meds”. Medication orders must be complete, accurate, and timely.

Medication orders will include:

- The drug name
- Strength
- Dosage form
- Route of administration
- Dosage regimen

PRN medication orders must include the symptom or indication for use.

2.3.1.5. Oxytocic Medications

OB/GYN Department Rules and Regulations concerning use of these medications will be utilized and followed.

2.3.1.6. Investigational Drugs and/or Devices

In the event that an investigational drug or device is requested to be administered/used, current hospital policy shall be followed.

2.3.1.7. Medication Substitution

Generic equivalents will be routinely used unless the LIP specifically orders “brand only” or the P&T committee has established an exception. .

2.3.2. Blood and Blood Products: SEE HOSPITAL POLICY, [BU-002](#), BLOOD AND BLOOD COMPONENTS.

2.3.3. Diagnostics:

2.3.3.1. Laboratory:

- Reflex Orders – See MEC Approved [Reflex Lab Testing.doc](#)
- Critical Values – See [Lab Order Groups Disease Panels.doc](#)
- Other Lab Policies – See table below. Policies can be found on the hospital intranet system (P:drive).

Topic	Policy Title	Number (link)
<b>Blood Bank</b>		
Blood/Blood Components	Blood/Blood Components: Procuring/Storing, Prescribing /Ordering, Preparing /Releasing, Administering, Monitoring for Transfusion Reactions and Effectiveness	<a href="#">BU-002</a>

Topic	Policy Title	Number (link)
Meditech, Ordering	<b>Meditech, Order Entry-Placing Orders for Laboratory, Microbiology, Pathology, and Blood Bank</b>	<a href="#">IM-018</a>
Refrigerator, Surgery	Use of the Remote Blood Bank Refrigerator in the Surgery Department	<a href="#">BU-020</a>
Rhogam	Administration of Rh Immunoglobulin (Rhogam)	<a href="#">BU-061</a>
<b>Laboratory/ Micro/Pathology</b>		
Bloodborne Pathogen Exposures	Accidental Bloodborne Pathogen Exposures	<a href="#">HR-102</a>
Bloodborne Pathogens, Lab	Laboratory-Specific Precautions for Blood-borne Pathogens	<a href="#">IC-095</a>
Critical Values	Critical Test Values/Read Back (CVRB)	<a href="#">PC-016</a>
Cultures, Blood	Blood Culture Collection	<a href="#">PC-020</a>
Cultures, ED Follow up	Follow-up Care on Positive Lab Culture Reports on Emergency Department Patients	<a href="#">CC-053</a>
General policies, guidelines	<b>Guidelines for Clinical Staff Regarding General Lab Policies</b>	<a href="#">PC-091</a>
Heelstick collection, infant	<b>Collection of Laboratory Specimens by Heelstick from the Neonate</b>	<a href="#">PC-375</a>
Meditech, Ordering	<b>Meditech, Order Entry-Placing Orders for Laboratory, Microbiology, Pathology, and Blood Bank</b>	<a href="#">IM-018</a>
Pathology	Extent of Pathology Examinations	<a href="#">PC-017</a>
Prioritization, Lab	Prioritization & Expected Turnaround Time for Laboratory Tests	<a href="#">PC-013</a>
Specimen, Cytology/Histology	<b>Preparation and Handling of Specimens for Histology and Cytology Testing and Reporting</b>	<a href="#">PC-023</a>
Specimen, Lab requirements	Laboratory Specimen Requirements	<a href="#">PC-021</a>
Specimen, Microbiology	Collection of Microbiology Specimens for Microbiology Testing and Reporting	<a href="#">PC-022</a>
Specimen, Unacceptable	Unacceptable Laboratory Specimens: Reasons for Unacceptability and Action to Be Taken	<a href="#">PC-065</a>
Stat tests	Available Emergency or Stat Laboratory Tests	<a href="#">PC-012</a>
Therapeutic med levels	Drawing of Therapeutic Medication Level for Selected Medications	<a href="#">PC-087</a>
Transportation, Specimens by CTS	Transportation of Specimens and Medications Using Computerized Tube System (CTS)	<a href="#">GB-025</a>
<b>Other Frequently Accessed Topics:</b>		
Autopsy	Inquests and Autopsies	<a href="#">PR-021</a>
Care, Plan for Patient	Organizationwide Plan for Patient Care	<a href="#">PC-001</a>
Death	Patient Death: Pronouncement, Notification of Family, Medical Examiner, Autopsy, Care and Disposition of the Body	<a href="#">PC-367</a>
Event Reporting	Incident, Adverse Drug/Medication Error and Sentinel Events Reporting Systems	<a href="#">LD-049</a>
Identification	Patient Identification	<a href="#">PR-012</a>
Waived testing	See <a href="#">Waived Testing</a> portion of Table of Contents	

#### 2.3.3.2. Radiology

Consultation request forms for radiology shall be filled out completely. The Attending LIP is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes.

In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency LIP, policy MS-010, Radiology—Emergency Medicine Communication ([MS-010](#)) is to be followed.

## 2.3.4. Procedures

### 2.3.4.1. Definitions

#### 2.3.4.1.1. Operative procedures

Operative procedures are those procedures for which privileges are required, which in the usual and customary clinical setting may endanger the life and wellbeing of the recipient, and which require operative intervention by breaching the mucosal or skin barriers of the patient. These include:

- Any 'ectomy
- Any 'otomy
- Any 'oscopy
- Obstetrical deliveries or operative inductions
- Operative reduction of fractures
- Incisional or excisional biopsies
- Any amputations

#### 2.3.4.1.2. Invasive procedures

Invasive procedures are defined as those procedures for which privileges are required for performance, and that in a usual and customary clinical setting do not endanger the life or wellbeing of the recipient, and require only minor breach of mucosal or skin barriers of the patient. These include:

- Percutaneous needle biopsies
- Diagnostic and therapeutic angiographic procedures
- Percutaneous catheter drainage and therapeutic procedures

#### 2.3.4.1.3. Non-Invasive Procedures

Non-invasive procedures are defined as those procedures for which privileges are required for performance, and that in a usual and customary setting do not endanger the life or well being of the recipient, and do not breach skin or mucosa. These include:

- Cardioversion
- Therapeutic irradiation

Prior to hospital discharge the practitioner must assure that the patient meets the following criteria:

- Vital signs stable for 30 min
- Ability to swallow or cough
- Absence of respiratory distress
- Minimal nausea, vomiting, dizziness and/or pain
- Oriented as to person, place and time
- Ability to ambulate consistent with procedure and condition
- No significant bleeding or drainage from procedure site

- Complete discharge instructions ordered and understood by patient or responsible adult.

#### 2.3.4.1.4. Preoperative and Intraoperative Diagnostics, Post-Op Orders

The attending surgeon and the anesthesiologist will be responsible for ordering any and all appropriate pre-operative diagnostic testing on the patient, though the consulting physician may have additional orders.

In the unlikely event that more than one set of Phase I Recovery orders exists, the Anesthesiologist's orders will take precedence.

#### 2.3.4.1.5. Scheduling and Start Time

The rules for the scheduling of elective or non-emergency surgery will be as follows:

- The schedule is available for posting of cases at all times.
- The following information is required in order to post a case:
  - The patient's full name, Age, and Sex
  - Surgery procedure
  - Side/Site if applicable
  - Type of Anesthesia
  - Operating Surgeon
  - Time and name of person posting the case
  - Assistant Surgeon
- After the 7:30 time slots are filled the order of cases will be based on the time of the cases posted, availability of assistant surgeon, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.
- If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule. These cases will be scheduled in accordance with rule three (3) above and will be done as near to the time as a room is available in the order the case is posted.
- The time may be changed if it does not interrupt the normal schedule as determined by the Chairperson of Surgery.

Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon repeatedly or flagrantly is late, he may have his privilege to schedule 7:30 a.m. surgery suspended or may be referred to the Executive Committee for action.

#### 2.3.4.1.6. Pathology Examination

All operative procedures in which tissue or any material is removed shall have that tissue sent to the pathologist for examination except those tissues exempt from ~~for~~ pathological examination. The pathologist will perform a microscopic exam on all tissues that are applicable. The surgeon will decide if any of the following removed in surgery will be submitted to pathology, and must document the final disposition of the tissue in the operative report (i.e. "Tissue discarded appropriately"):

- Teeth
- Cataracts
- Foreign Bodies
- Toenails/Fingernails
- Nose Cartilage
- Hernia Sacs
- Bones without significant soft tissue
- Catheters
- Foreskin
- Skin/Old Surgical Scars
- Orthopedic Appliances
- Bladder Calculi

The pathologist's authenticated report shall be made a part of the patient's medical record.

#### 2.3.4.1.7. Dental or Podiatric Cases without MD/DO

When the operating/anesthesia team consists entirely of non-MD/DOs (i.e., dentist with nurse anesthetist, dentist with dentist anesthetist, or dentist anesthetist, etc.), there shall be a previously designated MD/DO immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia. This MD/DO must have submitted the necessary form attesting to his willingness to assume this responsibility.

#### 2.3.4.2. Obstetrics and Newborn Care

##### 2.3.4.2.1. Sterilization

Sterilization for the sole purpose of sterilization for either male or female patients may be done at the discretion of the attending LIP and the fully informed consent of the patient being sterilized.

##### 2.3.4.2.2. Abortion

Consultation shall be held, except in extreme emergencies, for all curettages or other procedures by which a known or suspected normal pregnancy may be interrupted. A negative pregnancy test will be considered a consultation. Abortions will be handled in the following manner:

- Abortions will not be done in this hospital solely on patient's request or demand.
- Abortions may be done only for therapeutic reason.
- The reasons for the abortion must be clearly documented in the medical record.
- Consultations required with one additional OB/GYN LIP who is a member of the medical staff
- All abortions done will be reviewed by the OB/GYN department

#### 2.3.4.2.3. Inductions

All induction patients start as outpatients. Admission orders should be written once sustained active labor is achieved.

Appointment times for elective inductions are limited. Scheduling of inductions is done by calling the labor and delivery nurse and will be based on medical necessity and space availability.

Any elective induction and repeat Cesarean section which is to be scheduled should have fetal maturity documented by either amniocentesis, serial ultrasound, or a combination of ultrasound and early exams. Bishop Scoring for elective inductions is recommended.

The reason for induction of labor shall be stated in the H&P or initial progress notes.

#### 2.3.4.2.4. Qualifications for Major Gynecological and Major Obstetrical procedures

Hysterectomy, Cesarean section and any surgery of the fallopian tube or ovary except postpartum tubal ligation shall be done only by LIPs board eligible or board certified in the specialties of surgery or obstetrics and gynecology. When postpartum tubal ligations are to be by LIPs board certified or board eligible in other specialties, a board certified or board eligible surgeon or obstetrician-gynecologist must be immediately available.

#### 2.3.4.2.5. Qualifications for Routine Obstetrical procedures:

Family Practitioners requesting obstetrical privileges must:

- Have an OB consultant who is a member of the medical staff and available for each case. This must be documented in the patient's chart upon admission. The OB Consultant cannot be

an "on call" LIP. The OB Consultant must meet the same ACOG availability standards as active OB staff for each case.

- Have the OB Consultant submit a letter to the Administrator and the Chairperson of OB/GYN verifying the coverage. It is the Family Practitioner's responsibility to insure the OB and Family Practice coverage twenty-four (24) hours a day, 7 days a week. (A copy of the consultant's letter is to be placed in the credentials file of both the Family Practitioner and OB consultant.)
- Be named, as well as the OB Consultant, upon the patient's admission.
- Have the OB Consultant present in-house on all regional/general anesthesia cases.

### 2.3.4.3. Sedation and Anesthesia Care

#### 2.3.4.3.1. Sedation/Anesthesia levels are defined as (Reference Policy AC-001):

**Minimal Sedation (anxiolysis)** – a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Moderate Sedation/analgesia** (formerly known as Conscious Sedation)– a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Deep Sedation/analgesia** – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**Anesthesia** – consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

2.3.4.3.2. Required documentation for initial and renewal privileging of sedation/anesthesia:

Minimal: Appropriate narcotics licensing

Moderate:

- Adherence to 2.2.4.4 standards
- Any one of the following
- Completion of ACGME or AOA accredited residency in Anesthesiology
- Demonstration of current clinical competence (verifiable successful performance of 6 procedures involving moderate sedation in the last 12 months)
- 6 proctored cases by properly credentialed LIP (Note: The criteria for privileging of the ability of the practitioner to recover the patient from brief episodic deep anesthesia during the induction of moderate anesthesia are met by the above i., ii, and iii.)
- Completion of the Moderate Sedation Knowledge Assessment Test with a passing score of at least 70%. If score is less than 70%, the LIP will retake the test until a passing score is obtained.

Deep: Completion of ACGME or AOA accredited residency in Anesthesiology

Anesthesia: Same as Deep

2.3.4.3.3. If sedation/anesthesia care is anticipated the practitioner must have the appropriate privileges for the level of sedation/anesthesia anticipated. The practitioner must specifically order the sedation/anesthesia to be performed. For all sedation/anesthesia other than minimal, a pre-sedation/anesthesia evaluation must be performed, and a written, signed, informed, invasive and operative procedure consent shall be obtained as per section 1.1.3.

The pre-anesthesia evaluation will include the appropriate information to evaluate the appropriateness of the selected level of anesthesia/sedation, maintenance of patient safety, and adequate patient monitoring.

During anything other than minimal sedation/anesthesia monitoring will include the presence of the Licensed Independent Practitioner, the presence of a crash cart with defibrillator and reversal agent medications. Monitoring equipment will include an EKG monitor, NIPB and pulse oximetry.

For all levels other than minimal, a post-sedation/anesthesia evaluation must be documented including:

- Return to baseline or >8 Aldrete score before monitoring equipment is removed
- Vital signs q 15 min x 2, then q 30 min x 1 unless reversal agents have been administered. If reversal agents have been

administered, vital signs should be monitored q 15 min x 4 then q 30 min x 2. If vital signs in either situation are not stable, more frequent monitoring should be considered.

#### 2.3.4.3.4. Moderate, Deep, and Anesthesia Levels of Care:

A pre-anesthesia assessment shall be entered into the medical records by an anesthesiologist no more than 48 hours prior to the procedure. It will include drug allergies, current medications, past anesthesia problems, special problems, ASA status, and results of relevant diagnostic studies. The pre-anesthesia assessment will be signed and dated by the anesthesiologist.

An anesthesia care plan will be developed to include date, recommended choice of anesthesia, techniques, risks, complications and alternatives discussed with the patient and family. The anesthesia plan will be signed and dated by the anesthesiologist. Prior to induction, anesthesia must reassess the patient.

Each inpatient given an anesthetic by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) shall have a post-anesthesia recovery care note written by an anesthesiologist or CRNA within 48 hours after surgery. Outpatients should have a note written prior to discharge. This note should include cardiopulmonary status, level of consciousness, complications, and need for follow-up care. Post-anesthesia notes shall be dated and timed.

The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, documented reassessment prior to induction, and post-anesthetic follow-up of the patient's condition. This includes patients with epidural, caudal, spinal, or saddle block anesthesia.

All patients who are going to undergo caudal, spinal, saddle block, or epidural anesthesia should have an IV started prior to the administration of the anesthesia.

In the event the anesthesiologist is not in the hospital, he or she may be reached through normal channels and will respond within thirty minutes of determination of the need for anesthesia.

#### 2.3.4.4. Dental Care

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

Dentist's responsibilities:

- A detailed dental history justifying hospital admission.
- A detailed description of the examination of the oral cavity and a pre-operative diagnosis.

- A complete operative/invasive report, describing the findings and techniques.
- The dentist is totally responsible for the oral or dental care.
- Progress notes as are pertinent to the oral condition.
- Discharge summary.

Physician responsibilities:

- Medical history pertinent to the patient's general health.
- A physical examination to determine the patient's condition prior to anesthesia and surgery.
- Supervision of the patient's general health status while hospitalized.
- LIP is not responsible for any dental care or consequences thereof.

The discharge of the patient shall be on written order of the dentist of the Staff.

#### 2.3.4.5. Podiatric Care

A patient admitted for Podiatric care is a dual responsibility involving the podiatrist and physician member of the Staff unless the Podiatrist has been determined qualified to perform and been granted full H&P privileges as documented on the privilege form as “performance of own patient’s H&P”.

Podiatrist's responsibilities:

- A detailed Podiatric history justifying hospital admission.
- A detailed description of the examination and pre-operative diagnosis.
- A complete operative/invasive report, describing the findings and techniques.
- The podiatrist is totally responsible for the Podiatric care.
- Progress notes as are pertinent to the Podiatric condition.
- Discharge summary.
- Co-discharge of the patient.

Physician responsibilities:

- Medical history pertinent to the patient's general health.
- A physical examination to determine the patient's condition prior to anesthesia and surgery.
- Supervision of the patient's general health status while hospitalized.
- Discharge summary.
- Co-discharge of the patient.

Podiatrists (DPM) will be considered to be qualified to perform a full H&P if:

- they have had experience in the performance of H&P’s during their residency training, and this training has been completed within the previous 5 years, and they have presented documentation of this to the MEC, or
- they have had experience in the performance of H&P’s during their residency training, but this training has been completed more than 5

- years ago, and they have performed 5 H&P's which have been co-signed by another MD to confirm accuracy and completeness, or
- they can document recent training and current competence by performing 5 H&P's which have been co-signed by another MD to confirm accuracy and completeness.

## **2.4. GENERAL**

### 2.4.1. Advance Directives

- 2.4.1.1. The hospital staff will determine whether a patient (inpatient or outpatient) has or wishes to make advance directives, and hospital and medical staff will honor those directives within the limits of the law and the hospital's mission, philosophy and capabilities. In the absence of the actual advance directive, and in accord with applicable state law, the patient's wishes should be documented in the patient's medical record by the LIP as appropriate to the patient's condition. The lack of advance directives will not hamper access to care and the hospital will provide assistance to patients who do not have an advance directive, but wish to formulate one. The LIP will assist the hospital in these endeavors.
- 2.4.1.2. The LIP is responsible for clearly indicating the withholding of services to resuscitate the patient in accordance with the patient's advance directives or the patient's legal representative's wishes in the event that there is no advance directive.
- 2.4.1.3. The LIP will document the appropriate indications for withholding or withdrawing life sustaining treatment (IV therapy, feedings, ventilation, etc.) when in accordance with the patient's advance directives or the patient's legal representative's wishes in the event that there is no advance directive.

### 2.4.2. Death

#### 2.4.2.1. Pronouncement of Death

In the event of a Hospital death, the deceased shall be pronounced dead by the Attending Practitioner, or another member of the Staff designated by him, within a reasonable time, in accordance with the laws of the State of Texas.

The Attending Practitioner or his LIP designee is expected to make a bedside pronouncement if requested by the family or felt appropriate by the Nursing Staff.

#### 2.4.2.2. Release of Body

The body may be released after an entry has been made and signed in the medical record of the deceased by a member of the Staff or, if the death was expected, on the verbal order of a member of staff.

Under certain circumstances the attending LIP, or his LIP designee, may authorize release of a body to a funeral home without personal attendance. All of the following conditions are required:

- Death has been expected and the family has been prepared for it by the attending LIP who documents it in the patient's chart.
- A written "No resuscitation" ("No Leo") has been entered in the patient's record.
- The Attending Practitioner or his LIP designee interprets the absence of vital signs as given by the Nurse, which she documents.

#### 2.4.2.3. Post-Mortem Examinations (Autopsy)

##### 2.4.2.3.1. Post-Mortem examinations required by Texas State statutes:

The Medical Examiner must be notified of all deaths which fulfill one or more of the following criteria:

- Death within 24 hours of admission or surgery
- Death of an incarcerated individual
- Death as the result or complication of:
  - Suicide attempt
  - Violent Act
  - Poisoning, ethanol or drug-related
- The cause of death cannot be certified by the attending
- The person is a child younger than eighteen years

##### 2.4.2.3.2. Post-Mortem examinations not required by Texas State statutes:

The attending LIP will be notified in all cases of death and will be able to request that the family member or person(s) with appropriate legal authority be contacted for consent to perform an autopsy. It is the attending LIP's prerogative whether or not to request an autopsy, however, the attending LIP is advised to strongly consider post-mortem examinations in the following instances:

- Deaths in which the cause is unknown
- Deaths due to unexpected medical or surgical complications
- Deaths in which the family has concerns
- Deaths in which there is a question of public safety issues
- Natural deaths waived by the medical examiner in the following categories:
  - Dead on arrival
  - Death within 24 hours of admission
  - Deaths associated with injuries during hospitalization
- Obstetrical deaths
- Neonatal or pediatric deaths
- Deaths from illness that may have a bearing on survivors or recipients of transplant organs
- Deaths from known or suspected environmental or occupational hazards

In the event that an LIP does not desire an autopsy, the hospital staff will contact the responsible person(s) with appropriate legal authority and determine whether or not an autopsy is desired.

#### 2.4.2.4. Definition of Brain Death

A person will be considered legally dead if, based on ordinary standards of medical practice, there is the irreversible cessation of spontaneous respiratory and circulatory functions.

If artificial means of support preclude a determination that spontaneous respiratory and circulatory functions have ceased, a person will be considered legally dead if in the announced opinion of a LIP, based on ordinary standards of medical practice, there is the irreversible cessation of all spontaneous brain function. Death will have occurred at the time when the relevant function ceased. Death is to be pronounced before artificial means of supporting respiratory and circulatory functions are terminated.

A LIP who determines death in accordance with the provisions in the above section of this Act is not liable for damages in any civil action, or subject to prosecution in any criminal proceeding for his or her acts, or the actions of others based on that determination.

A person who acts in good faith in reliance on a determination of death by a LIP is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his or her act.

#### 2.4.3. Infection Control

The Infection Control Plan must be adhered to by all members of the medical staff. The Infection Control Coordinator and the Infection Control Medical Advisor have the authority to institute appropriate control measures or studies when there is evidence of an infectious condition that may be a hazard to others within the hospital. The Board of Trustees shall oversee the continual process of implementing and maintaining the Infection Control Program at South Austin Hospital and delegates to the Infection Control Committee the authority to determine and enforce the policies and procedures for all hospital departments and services relating to aseptic, isolation, and sanitation techniques.

## 2.5. SPECIALIZED CARE DEPARTMENTS

Specialized patient care policies may be utilized in other Medical Staff Departments. Please refer to separate medical staff department policies, rules, or regulations.

### **3. ARTICLE III - MEDICAL STAFF MEMBER'S RESPONSIBILITY FOR MEDICAL RECORD DOCUMENTATION**

#### **3.1. GENERAL**

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

All clinical entries in the patient's medical record shall be accurately timed, dated, and authenticated.

In case of readmission of a patient, prior records shall be available for continuity of care.

Symbols and abbreviations may be used as per hospital policy.

If the LIP is deemed by the MEC to be out of compliance, the MEC will take the corrective action deemed most appropriate in the situation.

#### **3.2. AUTHENTICATION**

By authentication it is meant that the LIP may utilize his or her legal signature. The LIP must legibly print or stamp name below signature. It is noted that the HIM department maintains a list of those signatures for reference. Facsimile signatures which are legible will be acceptable. Electronic signatures via a computer are acceptable. No rubber stamp signatures are allowed.

The use of standard pre-dictated and formatted text is allowed. It is the responsibility of the dictating LIP to ensure that the proper format is used and that the dictation has been transcribed as desired before signing the document.

#### **3.3. HISTORY AND PHYSICAL**

3.3.1. All H&P's must be validated and countersigned (authenticated) within 24 hours.

3.3.2. Inpatient History and Physical:

A complete admission history and physical examination shall be recorded within twenty-four hours of admission. A complete history and physical includes the following elements:

- Chief complaint
- Sufficient information about the course and timing of symptoms to support treatment.
- Details of present illness or condition including when appropriate, assessment of the patient's emotional, behavioral and social status
- Relevant past social and family histories as appropriate to the age of the patient
- An inventory of body systems
- Physical examination
- Diagnosis or problem list with plan of care
- Medications and allergies

Charts will be considered incomplete if an H&P is missing any of the above elements.

A complete history must be recorded and a physical examination performed within thirty (30) days prior to or within 24 hours after the patient's admission to the hospital but prior to surgery. A reasonable durable, legible copy of these reports may be used in the patient's Hospital medical record provided these reports were recorded by a member of the staff.

Any H&P written prior to the patient's admission requires an interval note at the time of admission or within 24 hours after admission but prior to start of surgery. It must document a physical reassessment and any changes in the patient's status as well as confirm the necessity for the procedure or care.

### 3.3.3. Pre-Procedural History and Physical:

All procedures performed in the operating suite require a complete History and Physical.

Ambulatory procedures not performed in the operating suite which place the patient at significant risk (including but not limited to procedures with IV moderate sedation and procedures without moderate sedation such as invasive radiology or cardiology procedures) require at least a short form H&P.

An update to the patient's condition (an update *interval note*) is also required in addition to the H&P for all ambulatory/outpatient procedures that places the patient at risk and/or involves the use of sedation or anesthesia within the first 24 hours.

If the LIP who is to perform the procedure deems and documents in a comprehensive manner in the patient's medical record that a delay would be detrimental to that patient's health and the rationale for the emergent procedure, a complete H&P will be waived until 24 hours after completion of the surgical procedure.

The Pre-Procedural History and Physical shall include at least the following:

- History must include:
  - Present illness including information about the course and timing of the symptoms to support treatment
  - Indications for procedure
  - Medications
  - Allergies, especially drug allergies
  - Past medical history
  
- Physical must include:
  - Airway, cardiac, and lung findings
  - Exam relevant to the procedure.
  - Mental Status

Charts will be considered incomplete if an H&P is missing any of the above elements. The Outpatient History and Physical Form may be used to fulfill the pre-procedural H&P requirements on an inpatient. A full H&P will still be required within 24 hours of admission as an inpatient.

### 3.3.4. Procedures performed outside the operating room including those that involve percutaneous or endoscopic penetration of deep body cavities (unless specifically noted below with image/ultrasound guidance and without moderate/conscious sedation) and/or are medicated to achieve a level of moderate/conscious sedation, require, at a minimum, the elements noted on

the Pre-Procedural History and Physical, and must be on the medical record prior to starting the procedure.

- 3.3.5. Procedures not outlined above and that are noted below do not require a history and physical examination:

Procedures Not Requiring History and Physical

Superficial Aspiration or Biopsy  
Outpatient CT  
Outpatient MRI  
Outpatient Ultrasound [US]  
Image Guided Myelogram Image  
Guided Cysternogram Image  
Guided Lumbar Puncture Image  
Guided Blood Patches Barium  
Studies  
IVPs  
Nerve Root injections  
Fact Injections  
Epidurals  
Cardiovascular Stress  
Bone Scan  
Renal Scan  
Lymphatic Studies  
Lung Scan  
GI Studies  
Endocrine Studies  
CNS Studies  
Stereotactic Breast Biopsy  
U/S Breast Biopsy  
U/S-Guided Thoracentesis  
U/S-Guided Paracentesis

- 3.3.6. Compliance with the above requirements and quality of the H&Ps will be routinely monitored by the medical staff.

### **3.4. PROGRESS NOTES**

- 3.4.1. Routine Progress Notes:

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 document the patient's response to treatment and the current plan of care.

- 3.4.2. Progress Notes when patient moves from one level of care to another:

The LIP will clearly document the patient's condition in the progress notes before and after the patient moves from one level of care to another.

- 3.4.3. Addendum Progress Notes:

The addendum progress notes for MI, CHF, and Pneumonia patients (aka Get With the Guidelines post-discharge orders) must be completed. If the form is not completed, the chart will be flagged as incomplete.

### **3.5. DISCHARGE SUMMARY**

A discharge summary (clinical resume) shall be written or dictated on all medical records of inpatients and include the following:

- The reason for hospitalization
- Significant findings
- Procedures performed and care, treatment and services provided
- The patient's condition at discharge
- Every medication dispensed or prescribed on discharge
- Instructions to the patient and family, as appropriate, including diet, activity, and follow-up

For newborns with uncomplicated deliveries, or for patients hospitalized for less than 48 hours with only minor problems a progress note may be substituted for the discharge summary (clinical resume). The progress note, which may be handwritten, documents the patient's condition at discharge, discharge instructions, medications, and required follow up care. The Outpatient History and Physical Form may also be used to document the progress note.

A discharge summary lacking these minimum items will be considered incomplete and therefore missing from the medical record.

### **3.6. PROCEDURE DOCUMENTATION**

#### **3.6.1. Operative/Invasive Procedures**

Operative reports shall be written or dictated immediately following surgery, and if dictated, a dated, timed and signed post-operative progress note is entered in the medical record immediately after the procedure prior to the patient being moved to another care area. The completed operative report is authenticated and filed in the medical record as soon as possible after surgery. Both the dictated operative report and the progress note include the following:

- Date of surgery/procedure
- The pre and post procedure diagnoses
- Procedure(s) performed
- Primary surgeon and assistant(s)
- Findings
- Specimens removed
- Estimated blood loss
- Type of anesthetic

If any of the above required elements are missing, the reports will be considered incomplete and not present in the medical record. Suspension of surgical scheduling privileges will occur if the operative/invasive report is not present in the medical record within three (3) days of the procedure. Operative/invasive reports are considered incomplete and therefore not present if any required minimum elements are missing.

#### **3.6.2. Non-Invasive Procedures**

The progress note will contain a description and outcome of any non-invasive procedure performed.

### **3.7. OBSTETRICAL RECORDS**

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

Patients having Cesarean sections or postpartum tubal ligations shall have an updated history and physical examination as well as a dictated operative report. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.

A physical examination and record of circumcision (if appropriate) shall be recorded in the medical record of all newborns.

### **3.8. EMERGENCY DEPARTMENT RECORDS**

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:

- Adequate patient identification.
- Information concerning the time of the patient's arrival and by whom transported.
- Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital and history or allergies.
- Description of significant clinical, laboratory and x-ray findings.
- Diagnosis including condition of patient.
- Treatment given and plans for management.

### **3.9. LIP CODING QUERY**

Clarification of the documentation within the medical record is sometimes necessary for coding and billing purposes. When needed, the appropriate LIP will be queried in written format utilizing the approved LIP Query form that remains a permanent part of the medical record. Once the query has been brought to the LIP's attention, diligent effort should be made to answer and sign the query within 72 hours. Records requiring physician response to a query will be tracked in the Medi-tech deficiency system. Failure to respond or inadequate documentation by the LIP on the LIP Query form will be referred to the Secretary of Medical Staff.

### **3.10. ACCESS**

The computerized medical record will be accessed only by those practitioners who are designated as Attending or Consultant LIPs. If an Attending Practitioner verbally asks a Consultant to see his or her patient, the Consultant and/or his call partner may order a Consultation on that patient as a verbal order from the Attending Practitioner.

Access to medical records will also be afforded consistent with hospital policy, state, and federal law.

Peer review of Medical Record should be performed only after authorization of the Chairperson of the Department, Medical Care Evaluation Committee, Medical Executive Committee or Chief of Staff. The violation of this rule will require investigation of the individual involved by the Medical Executive Committee with possible punitive action. 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.

According to state and federal statutes it is illegal to access or release any person's medical information in an unauthorized or inappropriate fashion. Confirmed intentional violation of authorized record review will be subject to the provisions of the St. David's Partnership Policy, Appropriate Access Violations by Medical Staff Members, Office Staff, and Allied Health Professionals.

### **3.11. REMOVAL**

Medical records are the property of the hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. Unauthorized removal of medical records from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Medical Executive Committee.

### **3.12. INCOMPLETE/DELINQUENT RECORDS**

All records are to be complete at the time of discharge. Records not complete at the time of discharge will be processed by the Health Information Management Department and made available to the LIP for completion. The medical record is delinquent within 30 days of the patient's discharge if incomplete. The medical record is deemed incomplete if any of the following are absent:

- Evidence of H&P within 24 hours of admission or prior to a procedure. (Any H&P written prior to the patient's admission requires an *Interval Note* at the time of admission and/or prior to the start of any surgery or invasive procedure that places the patient at risk and/or involves the use of sedation or anesthesia within the first 24 hours. It must document a physical reassessment and any changes in the patient's status as well as confirm the necessity for the procedure or care.)
- Results of consultative evaluations
- Authentication of practitioners' orders.
- Discharge summary or discharge progress note with final diagnosis within 30 days
- Reports of operative and invasive procedures
- Signed physician query form (if applicable).
- Addendum Progress Note (Blue "Get with the Guidelines" form)

If any of the above elements are incomplete thirty (30) days after discharge, the LIP will be suspended. The LIP will be notified prior to the suspension that he/she will be suspended on a certain date. On the day of suspension, the LIP will be notified of the suspension.

The suspension is automatic in the form of withdrawal of the LIP's elective privileges, and will continue until all delinquent medical records are completed in the form of signed or electronic authentication (see 3.2). The LIP is immediately placed on the delinquent list. The suspension does not apply to patients presently admitted to the institution or to elective procedures scheduled prior to suspension. The CMO or Chief of Staff may grant an exception only on documentation of extenuating circumstances such as the potential for adverse patient care/outcome if the elective procedure is not performed by the LIP..

After thirty (30) more days on the suspension list, *all remaining* hospital privileges will be automatically suspended and written notification of this action will be preceded by a written warning from HIM.

If a LIP remains on the suspension list for a period of ninety (90) days, a written warning from HIM will be given to the LIP stating that he/she has thirty(30) days to complete his/her records. The warning will state that failure to complete all delinquent records by the date indicated will be considered a voluntary resignation effective on that date.

Suspension of a LIP three times in any twelve (12) month period will constitute an automatic suspension of all hospital privileges for a period of two (2) weeks, beginning on the first day of the suspension. The CMO or Chief of Staff may terminate or prevent imposition of the automatic suspension only on presentation of documentation of extenuating circumstances such as illness or emergency that precluded completion of the medical records within the required time period. If the LIP has not completed all delinquent medical records at the end of the two (2) week period, the LIP's elective privileges shall remain suspended as occurs on a first or second suspension. All remaining hospital privileges shall be suspended if the records have not been completed thirty (30) days from the date the suspension was originally imposed and the procedures above for a first or second suspension shall apply.

Suspension of the LIP four times in any twelve (12) month period will be considered a voluntary resignation effective on the date the fourth suspension would be imposed. The LIP will be deemed not in "good standing" and will be reported to the Texas Medical Board for repeated medical record delinquencies in violation of the Rules and Regulations resulting in voluntary resignation from the Medical Staff.

In the case of a voluntary resignation, the LIP shall not be eligible to apply to the medical staff for a period of one year from the effective date of the voluntary resignation.

The LIP may be subject to corrective action pursuant to Article Ten, Section 10.1 of the bylaws in addition to the automatic actions set out above.

### **3.13. PERMANENT FILING**

A medical record shall not be permanently filed until it is completed by the responsible Practitioner(s) or is ordered to be filed incomplete by the Chief of Medical Staff.

### **3.14. RELEASE OF INFORMATION**

Medical staff members will receive information on patients in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines.

#### **4. ARTICLE IV – ADVANCED PRACTICE (ALLIED HEALTH) PROFESSIONAL AND SUPERVISING PRACTITIONER RESPONSIBILITIES**

##### **4.1. Advanced Practice Professionals must:**

- 4.1.1. Document their qualifications, current clinical competency, training, experience, demonstrated ability, and necessary health status to provide the support services (with or without reasonable accommodation) without posing a significant threat to the health or safety of patients, with sufficient adequacy to demonstrate that they can exercise judgment within their areas of competence; and provide services in accordance with accepted professional standards, provided that a member of the Medical Staff shall have the ultimate responsibility for patient care. AHPs may not exercise independent clinical judgment or originate any order except as provided in this appendix or the grant of clinical privileges.
- 4.1.2. Adhere strictly to the ethics of their respective profession, and work cooperatively with others in the delivery of patient care in the Hospital and all performance improvement and other medical peer review activities with regard to that care;
- 4.1.3. Immediately notify the Medical Staff Office of any changes in their status regarding sponsorship, supervision, address, licensure/certification/registration, liability insurance, participation in Medicare/Medicaid/other federal health care program, and termination of employment or other contractual relationship with the Sponsoring Practitioner;
- 4.1.4. Identify themselves verbally to the patient as the clinical professional described on the privilege description and wear an identification badge using the title described on the privilege description when working on hospital premises;
- 4.1.5. Familiarize themselves with all Hospital policies, procedures, protocols, and bylaws and agree to be bound and abide by the laws of the state, policies and bylaws of the Hospital, the Medical Staff, and any licensing board rules (i.e. Board of Nursing Examiners, Board of Medical Examiners, etc.);
- 4.1.6. Adequately document all patient encounters and educational activities;
- 4.1.7. May not take the place of a physician covering Emergency Department Call at this Hospital at any time for any reason;
- 4.1.8. May not screen calls from Hospital staff regarding patient care or prevent access of Hospital staff to the physician at any time; and
- 4.1.9. Be subject to and cooperate with the performance improvement and other medical peer review activities appropriate for AHPs of the Hospital and Medical Staff.
- 4.1.10. Keep a case log of patients seen and/or treated during period of appointment that shall be submitted along with application for reappointment and renewal of privileges. The case log will be used in conducting quality review and evaluation.

## 4.2. SPONSORING PRACTITIONER RESPONSIBILITIES

- 4.2.1. The Sponsoring Practitioner must be a physician, dentist or podiatrist member of the Medical Staff with clinical privileges appropriate for use of the AHP. The responsibilities and obligations of the Sponsoring Practitioner are set forth in this appendix and include without limitation to:
  - 4.2.1.1. Assume responsibility for the services rendered by the AHP and confirm acceptance of this responsibility in writing on the AHP's application;
  - 4.2.1.2. Retain the ultimate responsibility for patient care and be responsible for all acts of the AHPs under the Sponsoring Practitioner's supervision;
  - 4.2.1.3. Be responsible for the care of any medical problem that may be present or that may arise during the hospitalization of patients when also serving as the attending physician;
  - 4.2.1.4. Supervise and approve the procedures to be performed by the AHP as required by law and the grant of clinical privileges, and be available at any time for consultation on a patient seen by the AHP;
  - 4.2.1.5. Visit the Sponsoring Practitioner's patients at least once each day in accordance with Medical Staff Bylaws, regardless of the AHP's visits, when also serving as the attending physician;
  - 4.2.1.6. Conduct ongoing monitoring and evaluation of the AHP's exercise of clinical privileges and provide documentation of the AHP's competency to the satisfaction of the Hospital when requested;
  - 4.2.1.7. Notify the Medical Staff Office immediately of any changes in the AHP's sponsorship, employment or other contractual relationship with the Sponsoring Practitioner, or liability insurance, or participation in Medicare/Medicaid/other federal health care program; and
  - 4.2.1.8. Comply with all Hospital and Medical Staff Bylaws, Rules and Regulations, including without limitation this appendix.
- 4.2.2. AHPs may receive any required direction and supervision from another member of the Medical Staff designated by the Sponsoring Practitioner ("Alternate Sponsoring Practitioner" as listed on the sponsorship agreement). When providing supervision, the Alternate Sponsoring Practitioner has the same responsibilities and obligations of the Sponsoring Practitioner.
- 4.2.3. A Sponsoring Practitioner or any Alternate Sponsoring Practitioner who fails to provide the required level of supervision or who utilizes an AHP in violation of this appendix or the AHP's privilege description may be subject to corrective action under the provisions of the Medical Staff Bylaws.

## 4.3. LEVELS OF SUPERVISION BY THE SPONSORING PRACTITIONER

- 4.3.1. Levels of supervision at this Hospital are defined as:
  - 4.3.1.1. **Available:** The Sponsoring Practitioner must be available to the AHP within fifteen (15) minutes by telephone and able to be physically present in the Hospital within thirty (30) minutes of request if needed.
  - 4.3.1.2. **Indirect Supervision/Guidance:** The Sponsoring Practitioner must be able to be physically present in the Hospital within fifteen (15) minutes of request if needed.
  - 4.3.1.3. **Immediately Available:** The Sponsoring Practitioner must be present in the Hospital and immediately available to assist the AHP if needed.

- 4.3.1.4. **Direct Supervision/Guidance:** The Sponsoring Practitioner must be present during the provision of the services by the AHP.

#### **4.4. ADDITIONAL PROVISIONS FOR CERTAIN DISCIPLINES**

- 4.4.1. APN Defined: Advanced Practice Nurses (APNs) are registered nurses that have been authorized by the Texas State Board of Nurse Examiners to practice as nurse practitioners, clinical nurse specialists, nurse midwives, or certified registered nurse anesthetists.
- 4.4.2. PA Defined: Physician Assistants are licensed professionals that have been authorized by the Texas State Board of Medical Examiners to practice as physician assistants.
- 4.4.3. Orders must originate:
- 4.4.3.1. From the Sponsoring Practitioner and communicated through the PA/APN as a verbal order, or
  - 4.4.3.2. From Medical Executive Committee (MEC) approved protocol.
- 4.4.4. Protocols must be available to Nursing Staff on the unit where they are carried out, signed by the Sponsoring Practitioner and PA/APN, and updated and resigned at least annually. The PA/APN may select specific tasks or functions to perform within the scope of the protocol. If the tasks or functions ordered fall outside the scope of the protocol, the PA/APN must consult with the Sponsoring Practitioner and obtain a verbal order before a Registered Nurse will carry out the order. *(A Registered Nurse will seek clarification if he believes the order or treatment is inaccurate, non-efficacious, or contraindicated by consulting with the PA/APN and Sponsoring Practitioner as appropriate.)*
- 4.4.5. The PA/APN will document orders as: "V.O. per Dr. -----"/(name), P.A.." or "\_\_\_\_ (APN title)" or "per ----- protocol." All verbal orders must be dated, timed, and cosigned by the AHP and the Sponsoring Practitioner as provided in the Bylaws of the Medical Staff.
- 4.4.6. Prescriptive Authority
- If authorized by the privilege description and designated by the Sponsoring Practitioner with the Board of Medical Examiners as delegated to sign prescriptions, the PA/APN may administer, provide, carry out, or sign a prescription drug order for dangerous drugs and controlled substances Schedules III-V in compliance with the limitations of the Board of Medical Examiners, 22 Texas Administrative Code Section 194.6(n) (attached) only using the above procedures. APNs must have a Limited Prescriptive Authority granted by the Texas State Board of Nurse Examiners and their orders are limited to patient populations in the APN's specialty area. A Sponsoring Practitioner may not supervise more than three (3) PAs/APNs with prescriptive authority or their full-time equivalents.
- 4.4.7. Sponsoring Practitioner Responsibilities
- 4.4.7.1. The Sponsoring Practitioner and any Alternate Sponsoring Practitioners will have the following additional responsibilities with regard to a PA/APN:
    - 4.4.7.1.1. Review and authenticate history and physical examinations performed by a PA/APN within twenty-four (24) hours of the patient's admission and prior to any invasive procedures according to applicable Medical Staff Rules and Regulations;
    - 4.4.7.1.2. Review and co-sign the PA/APN's progress notes and inpatient orders (verbal or per protocol) (before implementation if required by protocol or the delineation of clinical privileges) within 24 hours according to applicable Medical Staff Rules and Regulations; and

- 4.4.7.1.3. Review the results of diagnostic studies ordered by the PA/APN and other evaluations within 24 hours according to applicable Medical Staff Rules and Regulations.
  - 4.4.7.2. PAs and APNs and their Sponsoring Practitioners are required by state law to provide written notification to the Hospital that the sponsoring relationship no longer exists;\*
  - 4.4.7.3. Sponsoring Practitioners for Physician Assistants (PAs) must be registered with the Texas State Board of Medical Examiners as required and may not supervise more than three (3) PAs or their full-time equivalents (but see further limitation in section 4.12.6 for PAs with prescriptive authority).
- 4.4.8. CRNAs: A physician may delegate to a CRNA the ordering of drugs and devices necessary for the CRNA to administer an anesthetic or an anesthesia-related service ordered by the physician. A physician's order for anesthesia need not specify the type of anesthesia drug(s) to be used, the dosage, or the administration technique, such being reserved to the discretion of the CRNA. The CRNA may select, obtain, and administer those drugs and apply the appropriate medical devices necessary to accomplish the order and maintain the patient within a normal physiological state. The Sponsoring Practitioner shall provide supervision of the CRNA to the extent required by law and the grant of clinical privileges and be immediately available while the CRNA is performing anesthesia services, but is not required to review or approve the actions of the CRNA.
- 4.4.9. Psychologists and Social Workers: Psychologists and social workers granted AHP status may provide services to a patient in the Hospital only at the request of a Medical Staff member who is the patient's attending Practitioner, as reflected by physician order in the hospital record. All services shall be provided in accordance with the rules and regulations of the state licensing boards and with the clinical privileges delineation, and shall not include the privilege to admit or prescriptive authority. Any treatment recommendations by the psychologist or social worker must be reflected in physician orders by the attending Practitioner prior to implementation. Psychologists shall not be required to have a sponsoring/supervising physician, and will be limited to providing care and services as delineated on their privilege forms. Quality Review and Competency will be monitored by the Medical Director.

# **MEDICAL STAFF DEPARTMENT RULES AND REGULATIONS**

Click on the following links to go to the specific document:

[Anesthesiology Department](#)  
[Cardiology Department](#)  
[Emergency Medicine Department](#)  
[Family Practice Department](#)  
[Internal Medicine Department](#)  
[OB/GYN Department](#)  
[Pathology Department](#)  
[Pediatrics Department](#)  
[Radiology Department](#)  
[Surgery Department](#)

## **HOSPITAL POLICIES AFFECTING THE MEDICALSTAFF APPROVED BY THE MEC**

Click on the following links to go to the specific document:

[AC-001, ADMINISTRATION AND MONITORING OF MODERATE  
SEDATION/ANALGESIA](#)

[MS-001, DELINEATION OF MEDICAL STAFF PRIVILEGES](#)

[MS-009, MEDICAL ADVISOR & MEDICAL DIRECTOR AUTHORITY,  
RESPONSIBILITIES, REPORTING](#)

[MS-010, RADIOLOGY--EMERGENCY MEDICINE COMMUNICATION](#)

[MS-11, CONFIDENTIALITY OF PEER REVIEW RECORDS AND THE  
MANAGEMENT AND MAINTENANCE OF PRACTITIONER FILES](#)

[PC-016, Critical Test Values Read Back](#)

[BU-002, BLOOD AND BLOOD COMPONENTS....](#)