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REVISIONS

Revised 10/97	**In Entirety**	
Revised 04/98:	**Section 2**	**Paragraph 2.2**
	Section 2	**Paragraph 2.6**
	Section 4	**Paragraph 4.2**
	Section 4	**Paragraphs 4.4 and 4.10**
	Section 4	**Paragraph 4.13**
	Section 4	**Paragraph 4.16**
	Section 4	**Paragraph 4.19**
	Section 11	**Paragraph 11.2**
	Section 13	**Paragraph 13.5**
	Section 17	**Paragraphs 17.12 and 17.13**
	Section 17	**Paragraph 17.14**
	Section 18	**Paragraph 18.3**
	Section 20	**Paragraph 20.1**
	Section 22	**Entire Section Added**
Revised 10/98	**Section 4**	**Paragraph 4.5**
	Section 4	**Paragraph 4.15**
	Section 4	**Paragraph 4.16**
	Section 4	**Paragraph 4.19**
	Section 11	**Paragraph 11.2**
Revised 06/99	**Section 4**	**Paragraph 4.2**
	Section 4	**Paragraph 4.16**
	Section 4	**Paragraph 4.17**
	Section 11	**Paragraph 11.2**
	Section 17	**Paragraph 17.7**
Revised 12/15/99	**Section 17**	**Entire Section Amended to Add Emergency Medicine**
	Sections 18-23	**Sections Renumbered due to Adding Emergency Medicine Section**
Revised 01/25/00	**Section 18**	**Paragraph 18.11**
Revised 05/23/00	**Section 4**	**Paragraph 4.17**
	Section 11	**Added Paragraphs 11.8 and 11.9**

Revised 01/23/01	**Section 3**	**Paragraph 3.1**
	Section 3	**Paragraph 3.3**
	Section 4	**Paragraph 4.2**
	Section 4	**Paragraph 4.15**
	Section 6	**Paragraph 6.3**
	Section 13	**Paragraph 13.2**
	Section 18	**Paragraph 18.9**
	Section 20	**DNR Guidelines, Paragraph G 4 added**
Revised 06/25/01	**Section 20**	**DNR Guidelines &P&P moved to Appendix A**
	Section 23	**Requirements for Moderate Sedation Privileges**
Revised 05/28/02	**Section 4**	**Paragraph4.8**
		Paragraph 4.9
		Paragraph 4.10
		Paragraph 4.15
		Paragraph 4.16
		Paragraph 4.19
Revised 09/24/02	**Section 4**	**Paragraph 4.17**
Revised 10/22/02	**Section 17**	**Paragraph 17.1**
		Paragraph 17.2
Revised 07/01/03	**Section 4**	**Paragraph 4.20 Added**
Revised 09/23/03	**Section 2**	**Paragraph 2.7 Added**
	Section 6	**Paragraph 6.3**
Revised 05/27/04	**Section 4**	**Paragraph 4.16 Added EEG Readings as records that must be complete**
Revised 06/22/04	**Section 3**	**Paragraph 3.1**
	Section 4	**Paragraph 4.2**
		Paragraph 4.5
		Paragraph 4.17
	Section 6	**Paragraph 6.5 New Rule**
	Section 7	**Paragraph 7.1**
		Paragraph 7.2
	Section 11	**Paragraph 11.5**
		Paragraph 11.8
		Paragraph 11.9
	Section 14	**Paragraph 14.1**
	Section 24	**Paragraph 24.1 New Rule**
	Appendix D	**New**
Revised 08/24/04	**Section**	**Paragraph 4.2**
Revised 11/23/04	**Section 18**	**Entire Section edited to change name to Emergency Department**
Revised 04/23/05	**Section 18**	**Paragraph 18.11**

Revised 05/24/05	**Section 17**	**Paragraph 17.2 Training Requirements for Emergency Medicine Applicants**
Revised 08/23/05	**Section 4**	**Paragraph 4.16 Automatic Suspension**
	Section 11	**Paragraph 11.8 New Surgical/Invasive Procedures**
		Paragraph 11.9 New Equipment for Surgical/Invasive Procedures
	Section 18	**Added a new paragraph regarding Medical Screening Exams; new paragraph is 18.3 and renumbered all following paragraphs within the section.**
Revised 11/22/05	**Section 4**	**Paragraph 4.2.1 H&P Exam, added language re: use of physical performed in office**
Revised 01/24/06	**Section 2**	**Paragraph 2.1 Responsibility for patient care transferred to another physician.**
Revised 03/28/06	**Section 3**	**Add Paragraph 3.6**
	Section 5	**Paragraph 5.1 additional language**
Revised 05/23/06	**Section 2**	**New Paragraph 2.2 adding time requirement for newborn to be seen by pediatrician. Moved Current paragraph 2.2 to 2.3 with all succeeding paragraphs numbering changed.**
Revised 11/28/06	**Section 4**	**Paragraph 4.16 Automatic Suspension. Changing time frame for OP Report to be on chart.**
Revised 01/28/07	**Section 3**	**Rule 3.1 Orders for Treatment**
	Section 4	**Rule 4.1, General Requirements, Rule 4.2, H &P**
	Section 11	**Rule 11.5, Anesthesia Record**
Revised 3/27/07	**Section 6**	**Adding Rule 6.7 Medication Reconciliation**
		Adding Appendix F
Revised 7/24/07	**Section 17**	**Paragraph 17.2 added or the equivalent where applicable.**
Revised 8/28/07	**Section 4**	**Paragraph 4.2 H&P; added Physician's PA or NP may record the H&P**
		Paragraph 4.17 OP Records; clarified that the physician performing the procedure physically saw the patient.
Revised 04/22/08	**Section 3**	**Paragraph 3.1 added all orders must be authenticated within 48 hours.**
	Section 4	**Paragraph 4.2 added the H&P must be in the patient's medical record within 24 hours of admission.**
	Section 13	**Radiology Section eliminated; wording within this rule edited to eliminate reference to Radiology Section.**
Revised 11/25/08	**Section 3**	**Orders for Treatment; added definitions of verbal and telephone orders; verbal orders not acceptable**
	Section 4	**Health Information Management; Paragraphs 4.2, 4.3, 4.4,4.6, 4.9,4.13, 4.16.**
Revised 07/28/09	**Section 4**	**Health Information Management; Paragraph 4.16 (added the word "timed" for consistency with other subparagraphs of Section 4).**

SECTION 1 ADMISSION OF PATIENTS

1.1 The Hospital shall accept patients for care and treatment except for patients with communicable diseases and mentally disturbed patients whose conduct would present a problem regarding their own or other patients' safety, care, and comfort.

1.2 Only a member of the Medical Staff and those practitioners holding temporary privileges pursuant to Article VII of the Medical Staff Policies & Procedures may admit patients to the Hospital. All such practitioners shall be governed by the Hospital's official admitting policy.

1.3 No patient will be denied admission on the basis of sex, race, age, religion, color, national origin or handicap.

1.4 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In an emergency, a provisional diagnosis shall be stated as soon as possible after admission.

1.5 Except for emergency admissions, patients shall be admitted in the priority in which the admitting practitioners inform the admitting office.

1.6 Patient transfer priorities are as follows:

(a) Emergency Department to appropriate patient bed;
(b) Intensive Care Unit to General Care Unit; and
(c) Temporary placement to the appropriate area for the patient.

1.7 The validity of an admission to or discharge from the Intensive Care Unit, if questioned, shall be determined through consultation with the Chairman of the Critical Care Committee or his designee.

1.8 Any patient known or suspected to be suicidal shall be transferred to adequate psychiatric accommodations. The admitting physician shall transfer the patient immediately to a facility with psychiatric accommodations when such are not available in the Hospital in order to protect patients, the medical and nursing staff and the Hospital.

SECTION 2 PHYSICIAN RESPONSIBILITIES

2.1 Each patient shall be the responsibility of a member of the Medical Staff who shall be responsible for the patient's medical care and treatment, the prompt completeness and accuracy of the medical record, necessary special instructions, and transmitting reports of the patient's condition to the referring practitioner and to the patient's relatives. A note covering the transfer

of responsibility shall be entered on the Order Sheet of the patient's medical record if these responsibilities are transferred to another practitioner. When responsibility for patient care is transferred to another physician, the transferring physician must document in the Medical Record that the patient's current care, treatment, current condition, and any recent or anticipated changes have been discussed with the Receiving Physician. The Receiving Physician must document in the medical record that all pertinent patient information has been received from the transferring physician. **OR** the Transferring Physician **may** use the preprinted Transfer of Physician Coverage Form to communicate this information to the Receiving Physician. The Transfer of Physician Coverage Form, **must** be signed by both the Transferring Physician and Receiving Physician. The signed form shall be faxed to the appropriate Nursing Unit for placement in the patient's medical record.

2.2 Newborns, who are born with no problems, shall be seen by the attending physician (pediatrician or family practitioner) within twenty-four (24) hours of birth.

2.3 Each applicant or member of the Medical Staff who admits patients or who provides clinical services shall designate one or more members of the Medical Staff in the same general specialty and with similar clinical privileges to provide coverage in his absence.
Exception to this coverage format will be granted only under the following conditions:

(a) Medical Staff applicant or member who is the only representative of a specialty on the Active Staff will be allowed to arrange back up coverage with a related specialty.

(b) Medical Staff applicant or member representing a specialty available at ODESSA REGIONAL MEDICAL CENTER, however, without a staff member willing to provide coverage with similar clinical privileges. In this instance, full-time practice coverage and availability (24 hours a day, 7 days per week) must be provided by the applicant or members. Back up coverage shall be arranged for emergency or planned absence as follows:

(1) Emergency absence is defined as any unplanned, sudden situation leading to the inability of a physician to cover his hospital responsibilities. In such a situation, the Chief of Section, or Chief of Staff will assist to arrange coverage during the emergency by a physician on the staff with similar clinical privileges, or if none is available, to arrange transfer to an institution where specialty care can be provided. While the emergency continues, all admitting and outpatient privileges, for which there is no similar overage prearranged, shall be withheld.

If a practitioner's personal patient is admitted to hospital, that practitioner will be responsible for the care of the patient.

(2) Planned absence is defined as any absence from the hospital, either educational, personal, or for any other reason which can be anticipated before it occurs. In such instance, the physician shall arrange temporary coverage (by a physician with similar clinical privileges).

2.4 Each member of the Active Staff and Provisional Staff who admits patients shall provide emergency call service and perform such other duties required by the Medical Staff Bylaws and these Rules and Regulations. Active staff members who are (1) at least 60 years of age or (2) have served on the Medical Staff for at least 20 years and who choose to, may request exclusion from emergency call service duties and shall be excused from such service upon approval by the Executive Committee and the Board. The Executive Committee may also excuse an active staff member from emergency call service and other responsibilities for a period not to exceed one (1) year under unusual circumstances such as health, disability, or extended absence. If such staff member requires excuse for a period greater than one (1) year, he may request review and further excuse by the Executive Committee. If no such review is requested, the Active Staff member shall be deemed to have requested a modification of his staff category from Active Staff to Courtesy Staff. Such a practitioner shall be deemed to have waived his procedural rights under Article IX of the Medical Staff Policies and Procedures, if he fails to request a review and further excuse.

2.5 No patient shall be transferred without the approval of the attending practitioner.

2.6 Each Medical Staff member shall be required to report to the Utilization Review Committee, upon request, the necessity for continued hospitalization of any patient. The report must contain:

(a) an adequate written record of the reason for continued hospitalization,
(b) the estimated period the patient will need to remain in the Hospital, and
(c) plans for post-hospital care.

A simple reconfirmation of the patient's diagnosis is not sufficient. The report must be submitted within 24 hours of receipt of notice or the failure to comply shall be brought to the attention of the Utilization Review Committee for appropriate action.

2.7 When one physician is covering for another physician, that covering physician is responsible for all of the other physician's obligations, including coming to admit a patient who is seen in the ER and requires admission. In addition, if the physician for whom coverage is being provided has agreed to cover for still another party, it would be the responsibility of the covering physician to cover those patients as well.
EXAMPLE: Physician A requests Physician B to cover for him/her. Physician A has previously agreed to cover for Physician C. Physician B would assume all responsibilities of Physician A,

which would include covering for Physicians A and C. It is the responsibility of Physician A to make Physician B aware of all duties that he/she has assumed prior to passing off to Physician B.

2.8 All members of the medical staff are highly encouraged to wear some form of visible identification which denotes their status at ORMC. A lab coat provided by ORMC with their name embroidered on it is acceptable. Photo ID badges will be provided by the Human Resources Office upon request.

SECTION 3 ORDERS FOR TREATMENT

3.1 All orders for treatment shall be in writing. Verbal and telephone orders order shall be considered to be in writing, if dictated to an appropriate staff member and signed by the responsible practitioner. The following staff members are considered as appropriate and may receive and transcribe verbal and/or telephone orders within the scope of their professional practice : Registered nurse, licensed vocation nurse, advance practice nurse, physician's assistant, physical therapist, physical therapy assistant, occupational therapist, certified occupational therapy assistant, speech language pathologist, and pharmacist, as well as personnel in the Respiratory, Laboratory and Imaging Departments. Members of Respiratory Therapy, Laboratory and Imaging Departments who may accept verbal orders shall be designated by the Medical Director and the applicable manager of said department.

Verbal orders are those received when the prescriber is physically present. Verbal orders are not acceptable unless the situation is emergent or procedural and immediate written or electronic communication is not feasible.

Telephone orders are those received via telephone by an appropriate staff member.
All verbal and telephone orders will be read back verbatim to the prescriber. The prescriber is responsible for providing confirmation that the read-back is correct. All verbal orders shall be signed by the person to whom the order is dictated and the ordering practitioner's name shall be indicated on the order. Verbal and telephone orders shall be dated, timed, and authenticated within 48 hours by the attending practitioner, or may be authenticated by another Active Staff member only if such member has shared the responsibility of the patient's medical care.

3.2 All 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. The use of “renew”, “repeat”, and “continue orders” is not acceptable.

3.3 All previous orders are canceled when a patient goes to surgery, enters or leaves another nursing unit. The use of “renew preoperative orders” is not acceptable.

3.4 Orders for respiratory therapy must indicate the intervals and method of therapy, the amount and types of drugs to be administered, the dilutent to be used, and the amounts of therapeutic gas to be used. Orders which fail to meet these standards shall be clarified before therapy is begun, unless the therapist decided that therapy should be done before clarification because of the emergent nature of the situation. If the written order is incomplete, the therapist shall attempt to reach the attending physician and/or his substitute. If this cannot be done in a reasonable time, the therapist should seek order clarification from the Manger of Respiratory Therapy. Therapy should be given in accordance with the guidelines set forth in the Respiratory Therapy Order Sheet or in consultation with the Respiratory Therapy Shift Supervisor.

3.5 No Code Blue" orders may be written or oral. When oral, "No Code Blue" orders must (1) be received by two nurses; (2) be signed by the physician within 24 hours; and (3) have documentation in the patient record that the situation had been discussed with the patient's family by the physician.

3.6 All orders for drugs and biologics, including verbal orders, must be legible, timed, dated, and authenticated with a signature, either by written or electronic form, by the practitioner or practitioners responsible for the care of the patient. **EXCEPTION:** Influenza and Pneumococcal vaccines administered in accordance with hospital policy for administering same, which has been approved by the Medical Staff and Governing Board.

SECTION 4 HEALTH INFORMATION MANAGEMENT

4.1 **General Requirements:** The attending practitioner shall be responsible for the preparation of a complete and legible medical record of each patient. The record shall be pertinent and current and shall include identification data, complaints, social history, psychosocial, family history, history of present illness, past history, review of systems, physician examination, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, evidence of appropriate consent, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, and autopsy report, when performed. All entries in the patient's medical record must be legible, complete, dated, timed, and authenticated by the person responsible for providing the service, either by written or electronic form by the person responsible for providing the service.

4.2 **History and Physical Examination**: A qualified physician, who is a doctor of medicine, a doctor of osteopathy, or a qualified maxillofacial surgeon who has been granted clinical privileges, shall be responsible for the patient history and appropriate physical examination. The medical history and physical must be recorded and placed in the patient's medical record within 24 hours of admission or prior to procedure, whichever occurs first. The

term admission includes inpatients, outpatients, including those admitted for any surgical or invasive procedure, and obstetric patients.
Non-physicians, such as dentists and podiatrists may be responsible for patient histories and physical findings respective to their areas of expertise. The attending dentist or podiatrist shall read and countersign histories and physicals recorded by physicians on dental or podiatric patients.
A licensed Physician's Assistant or Advance Practice Nurse, employed by the physician or maxillofacial surgeon, may record the History and Physical, if privileges have been granted to do so, and with proper countersignature.

If a complete physical has been performed in the office of a physician staff member or, when appropriate, a qualified maxillofacial surgeon staff member within 30 days prior to admission, a durable, legible copy of such exam may be used, provided the admitting physician notes that the H&P has been reviewed and any changes in the patient's condition are recorded at the time of admission in an update note. If there are no changes, that information must be noted. The update should be included on, or attached to, the original H&P. The updated record must be completed and placed in the patient's medical record within 24 hours or prior to procedure, whichever occurs first. For outpatient procedures, the update must occur the day of the procedure.

The updating of the H&P for surgical or invasive procedures should be completed by the physician performing the surgery or invasive procedure or other authorized practitioner with appropriate privileges to complete H&Ps and required updates.

The history and physical examination must be completed and recorded in the patient's chart before ~~a~~ any surgical or invasive procedure, or any potentially hazardous diagnostic procedure. If not, the procedure shall be canceled. In an emergency, when there is no time to record the complete history and physical examination, a note and the preoperative/pre-procedure diagnosis is recorded before the procedure.
If a patient is readmitted within 30 days for the same or a related problem, an interval history and physical reflecting subsequent changes may be used, provided the original history and physical examination information is readily available. The updated record must be completed and placed in the patient's medical record within 24 hours.

If a Consult History and Physical is completed by a practitioner with appropriate privileges and meets the time frame and update requirements as set forth in this section and fulfills the criteria of a History and Physical, it may be used as the History and Physical.

In all circumstances, the updating of the H&P must be completed and placed in the patient's medical record within 24 hours after the patient's admission, or prior to procedure, whichever occurs first.

Required elements of the particular H&P are as follows:

Inpatient History and Physical Assessment

The history shall include these specific elements:

- Chief complaint
- History of present illness
- Past medical history
- Family history
- Social history
- Current medications
- Allergies to medications and foods
- Review of systems
- Physical exam
- Impression
- Plan

Plan of Treatment (includes discretionary lab and radiology studies)

The physical assessment includes:

- General Appearance
- HEENT
- Heart
- Lungs
- Abdomen
- Extremities
- Mental Status
- Vital Signs**
- Impression

Those systems with positive or pertinent negative response must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. This assessment should be documented within 24 hours of admission unless surgical/invasive procedure is being performed. In the case where surgical/invasive procedure is being performed, the H&P must be present on the chart **PRIOR TO** the procedure.

Outpatient Invasive/Operative Procedure History and Physical Assessment

The history documentation requirements must include:

- Indications/symptoms to justify the procedure(s)
- List of current medications and dosage of each
- Known allergies/medication reactions; and
- Existing comorbid conditions (if any).

The H&P must be present on the chart **PRIOR TO** the procedure.

The extent of the physical examination required will depend upon the procedure to be performed and the anesthesia used as follows:

No Anesthesia or Topical-Local or Regional Block

- Vital Signs**
- Mental Status
- An examination specific to the procedure(s) proposed to be performed and any co morbid condition.
- Discretionary lab and radiology studies

Moderate Sedation

- Vital Signs **
- Mental Status
- An examination specific to the procedure(s) proposed to be performed and any co morbid condition
- Examination of the heart and lungs by auscultation
- Discretionary radiology and lab studies

Deep Sedation, General, Spinal or Epidural Anesthesia:

Same as inpatient

Observation Assessment

The history minimally includes:

- Chief complaint
- Details of present illness
- Past medical history
- Past surgical history
- Current medication and dosage
- Known allergies/medication reactions
- Significant or relevant family and social history
- Inventory by body system.

The physical exam includes the examination of the:

- General Appearance
- HEENT
- Heart
- Lungs
- Abdomen
- Extremities
- Mental Status
- Vital Signs**

- Impression
- Plan of Treatment (includes discretionary lab and radiology studies)

Those systems with positive or pertinent negative response must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. This assessment should be documented within 24 hours of admission unless surgical/invasive procedure is being performed. In the case where surgical/invasive procedure is being performed, the H&P must be present on the chart **PRIOR TO** the procedure.

Short Stay Summary:

The history minimally includes:

- chief complaint
- details of present illness
- past medical history
- past surgical history
- current medication and dosage
- known allergies/medication reactions
- significant or relevant family and social history
- inventory by body system.

The physical exam includes the examination of:

- General Appearance
- HEENT
- Heart
- Lungs
- Abdomen
- Extremities
- Mental Status
- Vital Signs**
- Impression
- Plan of Treatment (includes discretionary lab and radiology studies)

Short Stay is defined as patient stays under 48 hours. Final diagnosis is included in the discharge summary. Those systems with positive or pertinent negative response must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. This assessment should be documented within 24 hours of admission unless surgical/invasive procedure is being performed. In the case where surgical/invasive procedure is being performed, the H&P must be present on the chart **PRIOR TO** the procedure.

Emergency Service Assessment

As defined in Rules and Regulations Section 18, Emergency Services.

L&D Assessment

The current obstetrical record shall include a complete prenatal record. Such record may be a legible copy of the attending practitioner's office record, provided the date of the last office visit is within 30 days and an interval/update admission note is made, which includes pertinent additions to the history and subsequent changes in the physical findings. This updating of the record must be completed and placed in the patient's medical record within 24 hours after admission or prior to procedure whichever occurs first.

The office obstetrical record may serve as the H&P for the obstetrical patient **EXCEPT** for the patient with a C-Section delivery, or the date of the last office visit exceeds 30 days.

In the event a prenatal record is not available:

The history minimally includes:

1. Past medical history
2. Past surgical history
3. Current medication and dosage
4. Known allergies/medication reactions
5. First day of the last menstrual cycle
6. Significant or relevant family and social history
7. Inventory by body system.

The physical exam includes examination of:

1. General Appearance
2. HEENT
3. Heart
4. Lungs
5. Abdomen
6. Extremities
7. Mental Status
8. Vital Signs**
9. Impression
10. Plan of Treatment (includes discretionary lab and radiology studies)

Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. The H&P must be present on the chart **PRIOR TO** the C-Section procedure.

Newborn Assessment

"Newborn Infant Attending Physician's Record" – preprinted ODESSA REGIONAL MEDICAL CENTER form; discretionary radiology and lab studies.

Anesthesia Assessment

Each patient for whom anesthesia is contemplated shall have a pre-anesthesia assessment performed prior to the administration of anesthetics. A pre-printed Odessa Regional Medical Center form entitled, "Pre-anesthesia Evaluation" has been approved for completing this assessment and includes all the required elements. The pre-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours of procedure, with the exception of reassessment, which must occur immediately prior to induction.

A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after surgery or procedure for anesthesia services. This evaluation is required any time general, regional, or monitored anesthesia has been administered to a patient. Delegation to practitioners who are not authorized to administer anesthesia is not permitted. The post-anesthesia evaluation will include:

- Respiratory function, including Respiratory rate, airway patency, O_2 Sats,
- Cardiovascular function, including pulse and blood pressure
- Mental Status
- Temperature
- Pain
- Nausea/Vomiting
- Hydration Status
- Depending on the specific surgery or procedure performed, additional monitoring and assessment may be necessary as determined by the anesthesia provider.

**Vital signs in most instances will be documented by Nursing.

4.3 **Progress Notes:** Pertinent progress notes, sufficient to permit continuity of care, shall be recorded at the time of observation. Whenever possible, each clinical problem should be clearly identified in the progress notes and correlated with specific orders, test results, and treatment. Progress notes shall be recorded daily and must be dated, timed, and authenticated by the person responsible for providing the service, either by written or electronic form.

4.4 **Operative Reports:** Operative reports shall be dictated immediately following surgical procedures or invasive diagnostic or therapeutic procedures for outpatients and inpatients. Operative reports shall include a complete, detailed account of the surgical procedure and shall include, at a minimum, the following elements;

- Date and time of the procedure;
- Name of the individual performing the procedure, as well as all assistants or other practitioners involved in the procedure;
- Procedure(s) performed;
- Description of the procedure(s);
- Findings;
- Complications, if any;
- Estimated blood loss;
- Type of anesthesia/sedation administered

- Specimens removed;
- Description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues;
- Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;
- Pre operative diagnosis
- Post operative diagnosis.

Additionally, in order to provide continuity of care, a handwritten note (salmon-colored form) **must** be completed, timed, dated, signed, and placed on the chart **immediately** after any invasive procedure for both outpatients and inpatients. This written progress note should provide all the above elements concerning the procedure that was performed. This hand-written note **does not** eliminate the requirement that a complete operative note must be recorded.

4.5 **Consultations:** Consultations shall show evidence of a review of the patient's record, pertinent findings on examination, and the consultant's opinion and recommendations. The consultation report shall be made a part of the patient's record. A statement such as "I concur" does not constitute an acceptable report of consultation. Except in emergencies, so verified on the record, a consultation note shall be recorded prior to any operative procedures.

4.6 **Clinical Entries:** All clinical entries in the patient's medical record shall be accurately timed, dated and authenticated by the person responsible for providing the service, either by written or electronic form.

4.7 **Symbols and Abbreviations:** Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations shall be kept on file in the Health Information Management Department.

4.8 **Final Diagnosis:** The attending practitioner shall establish the final diagnosis. It shall be recorded in full, without the use of symbols or abbreviations, and date and signed at the time of discharge, **or dictated in the Discharge Summary.** The final diagnosis is of equal importance to the actual discharge order.

4.9 **Discharge Summary:** A discharge summary (clinical resume) shall be dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetric deliveries and normal newborn infants. A Progress Note may substitute for the clinical resume for normal obstetric deliveries and normal newborn infants who are hospitalized less than forty-eight (48) hours. A final summary shall be written or dictated on all patients who die in the Hospital. Summaries may be written or dictated by professional personnel designated by the attending

physician, provided the designee has the prior approval of the Credentials and Executive Committees. The content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end results, and shall include the following elements:

- The reason for hospitalization;
- Significant findings;
- Procedures performed and care, treatment, and services provided;
- Medications prescribed at discharge;
- Information provided to the patient and family as appropriate.

All summaries shall be completed within 48 hours of discharge and dated and authenticated, either by written or electronic form, by the responsible practitioner.

4.10 **Release of Information:** Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized to receive such information. All medical records are hospital property and may be removed only in accordance with a court order, subpoena, or statute. Unauthorized removal shall be grounds for suspension of clinical privileges for a period to be determined by the Executive Committee in accordance with Article VIII, Section 4 of the Medical Staff Policies and Procedures. If a patient is readmitted, all previous records shall be available to the attending practitioner.

4.11 **Access to Medical Records:** Free access to all medical records of all patients shall be afforded to Medical Staff members for bona fide study and research consistent with preserving the confidentiality of personal information concerning the identity of the patient. The Chief Executive Officer may, in his sole discretion, permit former Medical Staff Members access to the medical records of patients they attended.

4.12 **Filing of Records:** A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff Executive Committee, signed by the Chief of Staff, and evidence of such order attached to the Medical Record. All charts of a responsible practitioner who becomes disabled or expires shall be reviewed by the Medical Staff Executive Committee and filed as incomplete charts.

4.13 **Routine Orders:** Routine orders shall be reproduced in detail on the order sheet of the patient's record and dated, timed, and authenticated, either by written or electronic form, by the practitioner.

4.14 **Completion of Records:** At the time of discharge, except for pending labs, the chart shall be completed. If the practitioner is awaiting final laboratory or other essential reports, such information should be supplied to the Health Information Department on the face sheet. This information will be used by the Health Information Management Coder as a guide. The patient's chart will be available in the Health Information Management Department of the Physician

Dictation Room.

4.15 **Automatic Suspension:** The medical record shall be completed with **thirty (30)** days of discharge. Operative reports are required to be **dictated or written, and on the chart** within forty-eight (48) hours. If the completed operative report is not present on the chart within forty-eight (48) hours of the end of an invasive procedure requiring such report, the physician will be notified that privileges will be suspended unless the report is completed and on the chart within the third twenty-four (24) hours. Noncompliance will result in automatic suspension **of all privileges.** In order to maintain the required completion times for all medical records, the following rules shall apply:

The **Director of Health Information Management,** or designee shall notify the delinquent practitioner by fax **and mail** that his/her medical staff privileges shall be automatically suspended seven (7) days after the date of notice. Such notice to be sent on the Wednesday following the 25th day post discharge of the patient, if the medical record remains incomplete. At the end of this notice period, if the medical record still remains incomplete, **all privileges** of the delinquent practitioner shall be automatically suspended and such suspension shall remain in effect until the records have been completed. **Suspended physician records will be counted each week as an additional suspension until records are complete.**

The Director of **Health Information Management or designee** shall notify the Chief of Staff and the Chief Executive Officer of the delinquent practitioner. The Chief of Staff shall notify, by telephone, the delinquent practitioner of such automatic suspension. The delinquent practitioner shall be removed from the emergency call schedule and the Director of **Health Information Management** shall so advise the Express Care Center, **Admitting**, and Operating Room.

If and when a physician has acquired **five (5)** such automatic suspensions within a twelve (12) month period, he/she will be required to meet with the Physician's Affairs Committee of the Medical Staff Executive Committee. This Committee shall consist of four physician members from the Medical Staff Executive Committee, appointed by the Chief of Staff. One member of the committee must be the Section Chief of the Medical Staff Section of which the delinquent practitioner is a member. The delinquent practitioner, upon receipt of notice, will have five (5) days to meet with at least two members of this committee, one being the Chief of Section to which he is a member, to discuss and address his medical records suspensions of **five (5)** or more for the calendar year. If the delinquent practitioner, after meeting with the sub-committee members, should obtain one (1) additional suspension, this will results in an automatic two (2) week additional suspension. Any subsequent automatic suspensions within a twelve (12) month period shall constitute sufficient cause for revocation of Medical Staff Membership and Clinical Privileges in accordance with Article VII of the Medical Staff Policies and Procedures. The above sanctions shall not apply in the event of the delinquent practitioner's long term illness,

vacation in excess of seven (7) days, or other extenuating circumstances approved by the Executive Committee, provided the **Health Information Management** Department is notified in writing. Delinquent charts will be counted **multiple times for continuing delinquency.**
Emergency Department records, EKG and EEG readings are considered medical records for purposes of this Section. EKGs and EEGs must be read and dictated within three (3) calendar days of the date on which the EKG or EEG is placed in the physician's box. Failure to meet this requirement shall result in loss of Interpretation Privileges for the remainder of the calendar year, unless the Executive Committee excuses the physician upon request made within fifteen (15) days of the date of the third notice of delinquency.

Records placed in the practitioner's box for peer review must have the review completed within thirty days of being placed in the box. Failure to meet this requirement will result in automatic suspension.

4.16 **Signature, Date and Time:** All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by the person responsible for providing the service, either by written or electronic form, using written signature or identifiable initials. The use of rubber stamp signatures is not permitted in the medical record.

4.17 **Confidentiality of Health Care Information:** Under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, a clinically integrated setting such as a hospital and its medical staff is an organized health care arrangement. Members agree as a condition of their medical staff membership to participate in the organized health care arrangement and to comply with the Hospital's Privacy Policies and Procedures with regard to all patients admitted or treated by the Member in the Hospital or its outpatient clinics. All patients admitted to the Hospital or treated in a Hospital-owned facility will receive the Hospital's Notice of Privacy Practices, which shall be considered a joint notice of privacy practices of the Member and the Hospital. All Members will receive and complete privacy training from the Hospital at least annually.

SECTION 5 INFORMED CONSENT

5.1 Informed consent forms for any appropriate procedure or treatment shall be prepared by the Hospital with the aid of the Legal Department and adopted by the Medical Staff and the Board. The attending physician is responsible for securing informed consent on all designated medical and surgical procedures. The Physician or assigned designee is also responsible for discussing with the patient the following items, which are included in the Informed Consent Form and/or the attestation statement that the patient signs as part of the Informed Consent. The Physician or designee must sign the Informed Consent prior to the surgical procedure.

- The nature of the proposed care, treatment, services, medications, interventions, or procedures

- Potential benefits, risks, or side effects including potential problems that might occur during recuperation
- The likelihood of achieving goals
- Reasonable alternatives
- The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
- Other Practitioners aside from the primary physician which will be performing significant surgical tasks (significant surgical tasks include: harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues)
- When indicated, any limitations on the confidentiality of information learned from or about the patient

SECTION 6 MEDICATIONS

6.1 All drugs and medications administered to patients shall be listed in the latest edition of the U.S. Pharmacopoeia, National Formulary, American Hospital Formulary Service, or the AMA Drug Evaluations and shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigation of Drugs in Hospitals" and all regulations of the Federal Drug Administration.

6.2 The Pharmacy and Therapeutics Committee shall develop a method to control the use of dangerous and toxic drugs.

6.3 The following drugs will be automatically stopped unless the practitioner reviews orders: Antibiotics within ten (10) days, controlled substances within five (5) days, and anticoagulants within five (5) days. The practitioner shall renew all other medications within thirty (30) days.

6.4 Patients will be allowed to bring their own medications, provided all such medications are identified by the pharmacist and kept at the nursing station. The responsible practitioner shall order appropriate medicines in a routine fashion on the medication order sheet. If the patient's own medications are acceptable to the pharmacists to fill the order, such medications may be dispensed by the nurses from the patient's own stock. If a medication is not identified by the pharmacist, the practitioner shall decide whether the patient needs the medication.

6.5 Verbal orders for medications can be taken by licensed personnel only.

6.6 The use of rubber stamp signatures is <u>not permitted.</u>

6.7 In order to safely manage medications for the patient, there must be documentation that medication reconciliation has been performed by the patient's physician. That documentation

will be accomplished by utilizing the Medical Reconciliation Form approved by the Medical Executive Committee. The approved form, along with instructions for proper completion is included as a part of this rule and will be Appendix F to these Rules & Regulations.

SECTION 7 DIAGNOSTIC EXAMS / PROCEDURES: Laboratory, Radiology, Cardiology Respiratory Therapy

7.1 Diagnostic tests in the departments of Cardiology, Laboratory, Radiology, or Respiratory Therapy shall be provided only on the order of practitioners with clinical privileges to do so. The medical record should reflect an up-to-date evaluation of the hematocrit, white blood count, differential, and urinalysis. This information may be supplied from the attending practitioner's record. A section or department may alter these requirements, provided the altered requirements meet accrediting standards.

7.2 Requests for outpatient tests in the departments of Cardiology, Laboratory, Radiology, or Respiratory Therapy may be ordered by any practitioner holding a Texas License, and/or permitted by Texas Law to do so.

SECTION 8 CONSULTATIONS

8.1 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. He shall provide written authorization to permit another attending practitioner to attend or examine his patients, except in an emergency. Judgment as to the serious nature of the illness and doubt or questions as to the diagnosis and treatment rests with the attending practitioner, subject to the duty of the organized Medical Staff through its Section Chief and its Executive Committee to see that practitioners do not fail to call consultants.

8.2 Except in an emergency, consultation is indicated in the following situations:

(a) major surgical cases in which the patient is not a good risk;
(b) when there is doubt as to the best therapeutic measures to be utilized;
(c) unusually complicated situations where specific skills of other practitioners may be needed;
(d) instances where the patient exhibits severe psychiatric symptoms; and
(e) when requested by the patient or his family.

8.3 Any qualified practitioner holding clinical or consulting privileges may be called for consultation

within his area of expertise. A satisfactory consultation includes examination of the patient and the patient's record and a written opinion and recommendations signed by the consultant and made part of the medical record. When operative procedures are involved, the consultation note shall be recorded or dictated prior to the operation, except in emergency. Consultations by practitioners associated in the same office and specialty should be avoided if possible. When consultation is required under Hospital rules or in circumstances of grave urgency, the Chief Executive Officer shall at all times have the right to call in a consultation (s) after conference with the Chief of Staff or Section Chief.

8.4 If a nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he shall call these matters to the attention of the supervisor who in turn may refer the matter to the Director of Nursing Services. The Director of Nursing Services may bring the matter to the attention of the Section Chief in which the practitioner has clinical privileges. The Section Chief may request a consultation if warranted by the circumstances.

SECTION 9 DISCHARGE OF PATIENTS

9.1 Patients shall be discharged by written or verbal order of the attending practitioner. If a patient leaves the Hospital against the advice of the attending practitioner without proper discharge, a notation shall be made in the patient's medical record and the patient requested to sign a release for leaving the Hospital against medical advice.

9.2 When a patient is transferred to another medical facility, a statement of prognosis and/or rehabilitation potential should be stated in the discharge summary.

SECTION 10 DISASTER

10.1 A Disaster Plan for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community, shall be developed by the Fire/Safety Committee. The Plan shall be approved by the Medical Staff and the Board.

10.2 The Disaster Plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community service agencies participate. The drills should be realistic and must involve the Medical Staff as well as administrative, nursing, and other Hospital personnel. Actual evacuation of patients during such drills is optional. There shall be a written report and evaluation of all drills.

SECTION 11 SURGERY RULES

11.1 The Chief of Section shall investigate all complaints referred by proper sources. He/she shall refer all recommendations for disciplinary action, changes in surgical privileges, or changes in staff status to the Executive Committee in accordance with the Medical Staff Bylaws.

11.2 Before surgery or other invasive procedure, the patient's physical examination and medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record. In an emergency, when there is no time to record the complete history and physical examination, a note and the preoperative diagnosis is recorded before surgery.

11.3 A patient admitted for dental or podiatric care is the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff.

(a) Dentist or Podiatrist Responsibilities

(1) A detailed dental or podiatric history justifying the admission. An oral surgeon who admits a patient without medical problems may complete an admission history and physical examination and assess the medical risks of the procedure, if qualified to do so.

(2) A detailed examination of the oral cavity or foot and a preoperative diagnosis.

(3) A complete operative report describing the findings and techniques. The dentists shall clearly state the number of teeth and fragments removed. The tissue removed for podiatric procedures shall be sent to the Pathology Department.

(4) Progress notes pertinent to the oral or podiatric condition.

(5) Clinical resume or summary statement.

(b) Physician's Responsibilities:

(1) Examination except when performed by a qualified oral surgeon as set forth in Subsection (a) (1) above, the responsibilities set forth in Subsections (a) (1) and (2) above.

(2) Medical history pertinent to the patient's general health.

(3) A physical examination to determine the patient's condition prior to anesthesia and surgery.

(4) Supervision of the patient's general health status while hospitalized.

(c) The patient's discharge shall be on a written order of the dentist or podiatrist Medical Staff Member.

11.4 Written, signed, informed consents shall be obtained prior to the operative procedure except in an emergency. An emergency involving a minor or unconscious patient in which consent cannot be immediately obtained from parent, the guardian, or next of kin should be noted and fully explained in the record, and consultation may be desirable. Unless it is impossible, a surgeon shall first obtain the opinion of another physician regarding the necessity of surgery upon a minor in the following circumstances:

(a) The parent, guardian or person standing in loco parentis cannot be contacted.

(b) The identity of the minor is unknown.

(c) Delay could worsen the minor's physical condition.

(d) Parents refuse to consent and delay would endanger the life or seriously worsen the minor's physical condition.

11.5 The anesthetist or anesthesiologist shall maintain a complete anesthesia record, which includes evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. With respect to inpatients, a post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. With respect to outpatients, a post-anesthesia evaluation for proper anesthesia recovery will be completed. A qualified assistant must be present and scrubbed for any surgical procedure with unusual hazard to life. Qualified personnel approved by the Operating Room Supervisor and the Section of Surgery may act as first assistants in major surgical cases at the discretion of the operating surgeon. Anesthesia service will be available within 30 minutes for OB and emergency operative services.

11.6 For all therapeutic abortions, a consulted opinion must be obtained from at least two (2) licensed physicians on staff of this facility, other than the one who is performing the procedure. This opinion shall state that the procedure is medically indicated. The consultants may act separately or as a special committee. One consultant should be qualified as an Obstetrician-Gynecologist and one should have special competence in the medical area in which the medical indications for the procedure reside. The consultant shall made and sign a record of his findings and recommendations in every such case. In all cases where a rule of the Hospital requires consultation, and in the case of indigent patients, the consultant shall give his services without charge.

Therapeutic Abortions for medical reasons are to be done after consultation with a member of the active staff. The consultations shall be done and recorded before the procedure is carried out. Therapeutic abortion may be performed by the following medical indications:

1. When continuation of the pregnancy may threaten the life of the woman or seriously impair her health. In determining whether or not there is risk to health, account may be taken of the patient's total environment, actual or reasonably feasible.

2. When continuation with the pregnancy is likely to result in the birth of a child with grave physical deformities or mental retardation.

11.7 All tissues removed at an operation shall be sent to the hospital pathologist who shall make such examination as necessary to arrive at a pathological diagnosis and shall sign his report. Exceptions to this policy may be made by the Medical Staff in consultation with the pathologist and should be made only when the quality of care has not been compromised, when an alternative method of verification of the removal has routinely been employed, and where there is an authenticated operative or other official report that documents the removal. The categories of specimens that may be exempted from the examination requirements include, but are not necessarily limited to, the following:

(a) Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body or portion of rib removed to enhance operative exposure.

(b) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

(c) Traumatically injured members that have been amputated and for which examination for medical or legal reasons is not deemed necessary.

(d) Foreign bodies that are given directly to law enforcement representatives (e.g., bullets).

(e) Specimens which rarely if ever show pathological change, and the removal of which is highly visible post operatively (e.g., foreskin from the circumcision of a newborn infant).

(f) Teeth, provided the number (including fragments) is recorded in the medical record.

11.8 <u>New Surgical/Invasive Procedures:</u>

A new surgical / invasive procedure is defined as one that has not previously been performed at

ODESSA REGIONAL MEDICAL CENTER. In order for a new surgical/invasive procedure to be considered at ODESSA REGIONAL MEDICAL CENTER, the practitioner who wishes to perform the procedure must first present a request to the Chief of the requesting practitioner's Section. The Section Chief shall then name an ad hoc committee, comprised of a minimum of two members of the Section and the Section Chief. The Section Chief shall serve as Chair of the ad hoc committee and shall call a meeting, at which the requesting practitioner will provide information that will detail the procedure, the necessary training for performing the procedure, and the equipment that will be required to perform the procedure. In addition, the type of training required for ancillary staff in order to assist with the procedure must also be provided. Findings of the ad hoc committee will be forwarded to the Credentials Committee for review and recommendation to the MEC for approval or denial of the request. If the recommendation from the Credentials Committee is not for approval, the practitioner may appeal their decision to the Medical Staff Executive Committee. Findings and decisions by the Medical Staff Executive Committee shall be final. If and when the new procedure is approved, a recommendation for addition of the procedure to the appropriate Delineation of Privilege Form shall be sent to the Credentials Committee. If the procedure is approved, the practitioner must apply for the additional privilege in the usual manner and must provide evidence of satisfactorily completing the program training. All practitioners who wish to perform the new procedure shall apply for the additional privilege in the usual manner.

11.9 New Equipment For Surgical/Invasive Procedures

New equipment is defined as that which has not previously been present for use at ODESSA REGIONAL MEDICAL CENTER. In order for a new piece of equipment to be used for accomplishing surgical/invasive procedures, a full description of the equipment, along with the training required to operate it, and its intended use shall be provided to the requesting practitioner's Section. The practitioner(s) who will be using the new equipment must provide evidence of proper training on the equipment. The request shall be reviewed at the next regularly scheduled meeting of the Section. In the event an immediate decision is required, the Section Chief shall name an ad hoc committee, comprised of a minimum of two members of the Section and the Section Chief to discuss the request. The recommendation of the ad hoc committee shall be forwarded to the Credentials Committee for review and recommendation to the MEC for approval or denial of the request.

SECTION 12 THE SECTION OF OBSTETRICS AND GYNECOLOGY, GUIDELINES FOR FAMILY PHYSICIAN DOING OBSTETRICS

12.1 All family physicians who are approved to practice obstetrics at the hospital must first have been approved for family practice.

12.2 Approval for obstetrics shall be based on adequate documentation of the practitioner's previous adequate experience in routine obstetrics during a Family Practice Residency. Depending on previous experience, the family physician may require direct supervision when first starting an obstetrical practice at the hospital, until he has shown adequate skills in delivery and in patient management.

12.3 Family physicians shall be expected to provide only routine obstetrical care, involving normal labor and normal spontaneous delivery in healthy patients who have developed no obstetrical or other medical complications and with appropriate consultation for unexplained complications.

12.4 Family physicians who have adequate experience in elective low forceps deliveries may also use this method of delivery. Only local pudendal block anesthesia, or assistance from the anesthesia nurse, would normally be used by the
family physician. In cases of special training, approval for conductive anesthesia may be granted on an individual basis.

12.5 The Section of Obstetrics and Gynecology shall review random charts of each family physician at the end of his first year of Provisional Staff membership and shall make recommendations regarding Active Staff membership and full obstetrical privileges.

12.6 The Section of Obstetrics and Gynecology requires that the family physician consult an obstetrician/gynecologist of his choice for all non-routine pregnancies.
Non-routine pregnancies shall include those involving:
(a) medical problems relating to pregnancy;
(b) obstetrical complications; and
(c) patients with previous Caesarean Sections, as described below:

(a) Medical Problems Relating to Pregnancy

1. Insulin dependent diabetes mellitus.
2. Moderate or severe hypertension in pregnancy.
3. Cardiopulmonary disease compromising the patient's normal function.
4. Other medical conditions that are affected by pregnancy, or have a detrimental effect on pregnancy.

(b) Obstetrical Complications

1. Multiple births.

2. Breech presentation.
3. Other abnormal presentations.
4. Failure to progress in active labor (such as cephalopelvic disproportion or uterine inertia).
5. Abnormal bleeding in the third trimester or in labor.
6. Prolonged premature rupture of membranes.
7. Fetal distress.
8. Post partal emergencies (such as post partum hemorrhage, or other serious complications).

(c) <u>Previous Caesarean Section</u>

All patients with a previous Caesarean Section delivery should be referred to an obstetrician for obstetrical care and delivery.

The Family Physician is expected to use the fetal monitoring equipment, Pitocin infusion pumps and other laboratory tests or equipment, as appropriate.

12.7 Guidelines for Ultrasound Credentials **(Level I)**

To obtain privileges for Level I Ultrasound in labor and delivery, the following requirements must be met:

1. Physician must have obstetrical privileges on the staff of ODESSA REGIONAL MEDICAL CENTER.
2. Physician must document formal training. (Minimum of 12 hour course.)
2. Physician must submit written recommendation from Chief of OB/GYN Section at previous affiliation.

All physicians must meet basic credentials divided into the following two categories:

CATEGORY A: Non-OB/Gyn physicians must have cases supervised by a proctor, who will be an OB/GYN physician.

CATEGORY B: Physician who is a recent graduate of an OB/GYN residency program must document proficiency in ultrasound techniques and provide written confirmation from the Chief of Residency Program of his or her proficiency.

<u>SECTION 13</u> THE RADIOLOGY SECTION QUALIFICATIONS AND CREDENTIALING

13.1 The practice of radiology and medical imaging shall be maintained for the benefit of the patients and staff practitioners. The practice of medical imaging shall include but not necessarily be confined to:

(a) fluoroscopic, computed tomographic and x-ray film image production and interpretation.
(b) ultrasound (with the exception of echocardiography).
(c) all production of ionizing radiation.
(d)` digitized and computer generated radiography.
(e) interventional, therapeutic, and diagnostic procedures utilizing medical imaging for guidance.

13.2 The practice of radiology and medical imaging shall be under the supervision and direction of the Section of Medicine. The official report for all images produced at the Hospital will be the product of physicians who have been granted privileges for diagnostic and/or interventional radiology procedures and hold an appointment to the Section of Medicine. All imaging films produced at the Hospital will be read by a physician member of the medical staff, who has been granted privileges for diagnostic and/or interventional radiology procedures. This includes films transmitted via Tele-Rad. There shall be three categories of appointment (a) Active (b) Courtesy, and (c) Consulting.

(a) Active appointment requires the following:

1. Rotation through the Radiology work schedule in those areas in which the physician is credentialed / privileged.

2. Rotation on the on-call schedule in those areas in which the applying physician is credentialed.

3. All procedures interpreted by members who have been granted privileges for diagnostic and/or interventional radiology procedures will be the product of their management and will include, but not be confined to, the injection of contrast or manipulation of instruments as in ultrasound. A valid state license shall be required for section members using radioactive materials.

(b) Those radiologists who apply for the privilege of diagnostic radiology via Teleradiology, shall be eligible only for Consulting Status.

13.3 Radiation protection, quality control, regulation of personnel, scheduling of all other activities of administration and of management will be the responsibility of the Medical Director of Radiology.

13.4 Privileges may be requested by any staff member who has completed a formal residency training program in diagnostic imaging, nuclear medicine and/or radiation therapy. Physicians applying for privileges must meet the following criteria:

- proven competency in radiation physics
- radiation biology
- radiation safety
- radiation positioning and technique and
- demonstrated competency in the interpretation of these procedures by training and by experience.

13.5 Physicians applying for privileges must delineate the areas in which privileges are sought. In these areas, the applicant must have formal residency training, provide preceptor statements regarding competency, and demonstrate competency to the Credentials Committee, MEC, and Governing Board to assure adequate patient safety and patient management.

13.6 An appointment is not guaranteed by virtue of training alone.

13.7 Application for Courtesy Non-Interpretative privileges may be made by any staff member who has fulfilled the following requirements:

(a) Formal residency training in the designated privileges.

(b) Demonstrated competency to the Credentials Committee, MEC, and Governing Board regarding application of the designated privileges, adequate patient safety and management during the performance of these privileges.

The generation of ionizing radiation will always be in the presence of a staff member of the Department of Radiology (staff technologists or staff radiologist).

These privileges shall not include interpretation and dictation of the permanent record. Competency in radiation physics, radiation biology, radiation safety, radiation positioning and technique, radiation protection, and quality assurance is the responsibility of members who have been granted privileges for diagnostic and/or interventional radiology procedures and have been appointed as members of the Medicine Section.

SECTION 14 SECTION OF MEDICINE PRIVILEGING AND CREDENTIALING

14.1 The Medicine Section shall include physicians who have special training, competence, and interest in the broad field of Internal Medicine, its sub-specialties, Family Practice, and Radiology. Clinical privileges are granted according to the applicant's training, experience and current competency.

14.2 General Internal Medicine. The privileges to practice general Internal Medicine as a specialist in Internal Medicine shall be granted on the basis of:

(1) Board Certification in Internal Medicine, or
(2) Board Eligibility in Internal Medicine as currently defined by the American Board of Internal Medicine, or
(3) Demonstrated competency in Internal Medicine. When experience is weighted heavily in privilege delineation, the individual's credentials file should reflect the specific experience and successful results that form the basis for the granting of privileges.

14.3 Sub-specialities of Internal Medicine. The privilege to practice one of the sub-specialities of Internal Medicine shall be granted on the basis of:

(1) Board Certification in Internal Medicine, and
(2) Board Certification in the sub-speciality, or
(3) Board Eligibility for the sub-speciality board as currently defined by the American Board of Internal Medicine, or
(4) Demonstrated competency in the practice of the sub-speciality, when experience is weighted heavily in privilege delineation, the individual's credentials file should reflect the specific experience and successful results that form the basis for the granting of privileges.

14.4 Special Procedures done by Internal Medicine Specialists. The privilege to perform certain procedures shall be granted on the basis of demonstrated competency in performing the procedure. The individual's credentials file should reflect the specific experience and successful results that form the basis for the granting of privileges. Certain procedures have guidelines for the granting of privileges documented within these Medical Staff Rules and Regulations (Gastrointestinal, Endoscopy and Fiberoptic Bronchoscopy).

SECTION 15 GUIDELINES FOR GASTROINTESTINAL ENDOSCOPY PRIVILEGES

15.1 Each applicant applying for privileges in gastrointestinal endoscopy must be well versed in diagnosing and treating all diseases occurring in the organ he wishes to examine and endoscope. Additionally, he must be skilled and knowledgeable in the technique of the endoscopy procedure.

15.2 The following specialties may apply for privileges in gastrointestinal endoscopy:

Specialties	**Procedures**

Gastroenterology	Esophagostroduodenoscopy Total Colonoscopy Colonoscopy and Polypectomy Gastric Polypectomy Retrograde Cholangiopancreatography Retrograde Sphinecterotomy Laparoscopy Sclerotherapy Laser Therapy Flexible Sigmoidoscopy
General Surgery	Esophagogastroduodenoscopy Total Colonscopy Colonoscopy and Polypectomy Gastric Polypectomy Flexible Sigmoidoscopy Laparoscopy
Colon and Rectal Surgery	Flexible Sigmoidoscopy Total Colonoscopy Colonoscopy and Polypectomy

Requests for privileges from physicians and specialities other than those listed above or requests for privileges other than those listed above shall be considered on a case by case basis.

15.3 The criteria for acceptance as a qualified endoscopist with full privileges to perform the gastrointestinal procedures are as follows:

1. The applicant shall have successfully completed an approved residency and fellowship in the appropriate and recognized formal fields. The applicant shall have established his endoscopy skill as follows:

   He shall have completed his residency and fellowship training in his endoscopic procedures, using the guidelines of the American Society of Gastrointestinal Endoscopy, and be able to currently provide quality endoscopy for diagnosis and treatment in his field.

2. An applicant who has completed his formal training in his desired endoscopic procedure longer than one year before his application may be required to perform the first two to six procedures in the presence of a credentialed GI Endoscopist who will certify

proficiency after the period of observation.

Without prior endoscopic training in the desired procedure during a residency or fellowship program, the applicant can document competency by:

Active participation in intensified and specialized endoscopic courses which are to be recognized and approved by the Endoscopy Committee and/or

Demonstration in the presence of a credentialed Endoscopist of two to six procedures after which proficiency will be determined.

3. For physicians who have not had prior endoscopic formal training but who have performed gastrointestinal endoscopy procedures since training, competency can be documented by:

Review of cases supplied by the applicant and/or

The first two to six procedures will be done in the presence of a credentialed Endoscopist who will certify proficiency after the period of observation.

For privileges concerning new procedures not outlined above, each case will be individually reviewed. Self-training and new techniques occur in GI Endoscopy, but it must take place in the background of basic endoscopic skills. The Endoscopist shall have the integrity and insight to determine when and if additional training is necessary before undertaking a new procedure.

15.4 Physicians who have recurrent complications will have their privileges reviewed and all physicians will be reviewed after the first year of practicing gastrointestinal endoscopy procedures.

SECTION 16 GUIDELINES FOR FIBEROPTIC BRONCHOSCOPY PRIVILEGES

16.1 Each applicant for privileges in fiberoptic bronchoscopy must be well versed in diagnosing and treating all diseases occurring in the organ he wishes to examine and bronchoscope. Additionally, he must be skilled and knowledgeable in the technique of fiberoptic bronchoscopy.

16.2 The criteria for acceptance as a qualified bronchoscopist with full privileges to perform the bronchoscopy procedures are as follows:

(a) Physician with formal training in fiberoptic bronchoscopy and with practice no more than one year from time of application. No restrictions.

(b) Physician with formal training in fiberoptic bronchoscopy and more than one year before application.

(c) Physician without formal training in fiberoptic bronchoscopy who wishes to gain privileges in fiberoptic bronchoscopy may:

1. Attend a formal course or courses, approved by Endoscopy Committee:
   . First two to six procedures must be done with credentialed fiberoptic bronchoscopist present, who shall have the responsibility to certify proficiency after observation period; or

2. For physicians who are privileged in rigid bronchoscopy, but who have not had formal training in fiberoptic bronchoscopy and who have performed fiberoptic bronchoscopy since formal training, can document competency by:
   a. Presenting for review the cases previously bronchoscoped with the fiberoptic scope and/or
   b. The first two to six fiberoptic procedures must be done with a credentialed fiberoptic bronchoscopist present, who shall have the responsibility to certify proficiency after observation period.

16.3 Physicians who have recurrent complications will have their privileges reviewed and all physicians will be reviewed after the first year of practicing fiberoptic bronchoscopy procedures.

SECTION 17 SECTION OF EMERGENCY MEDICINE PRIVILEGING AND CREDENTIALING

17.1 The Emergency Medicine Section shall be limited to physicians who have special training, competency, and interest in the broad field of Emergency Medicine, or Family Practice or Internal Medicine. Clinical privileges are granted according to the applicant's training, experience and current competency.

17.2 Appointment Considerations: Applicants must demonstrate current certification from the American Board of Emergency Medicine (ABOEM), American Osteopathic Board of Emergency Medicine (AOBEM), or other equivalent boards of Emergency Medicine
OR
Completion of an ACGME or AOA accredited residency training program in Emergency Medicine;
OR
Current certification in Family Practice or Internal Medicine. Certification must be from a member board of the American Board of Medical Specialties (ABMS) or the American Board of

Osteopathic Specialties (AOA) **AND** provide evidence of a minimum of 1,000 hours emergency department experience within a twenty-four month period during the previous two years;
OR
Completion of ACGME or AOA accredited residency training program in Family Practice or Internal Medicine **OR** the equivalent where applicable.
AND
Provide evidence of a minimum of 1,000 hours emergency department experience within a twenty-four month period during the previous two years.

17.3 Appointment to the Emergency Medicine Section is not guaranteed by virtue of training alone.

<u>SECTION 18</u> EMERGENCY SERVICES

18.1 Emergency services are medical services rendered in the Emergency Department. Such services are ordinarily provided in the Emergency Department and associated laboratory and x-ray facilities.

18.2 The Emergency Department's purpose is to provide efficient and appropriate care to sick and injured patients. The objective of the Emergency Department is to provide emergency and life-saving care to all presented for treatment without regard to race, color, national origin or ability to pay.

18.3 All patients presenting to the Emergency Department shall have an appropriate medicalScreening exam to determine if an emergency medical condition exists, or if a woman is in active labor. The Medical Screening Exam (MSE) will be performed in the following areas and by the following Qualified Medical Persons (QMP):

A. <u>Emergency Department</u>
A physician will normally perform the MSE.
Exception: Patients who are triaged as level 4 or 5 by the Registered Nurse in the ED may be medically screened by a mid-level provider, i.e., a Physician's Assistant or a Nurse Practitioner.

B. <u>Labor and Delivery (L&D)</u>
The QMP is the Registered Nurse in L&D and the diagnosis of false labor must be certified by a physician, either in person or by phone. This certification will be achieved by way of a written or telephone order that must be signed by the physician.

18.4 An appropriate medical record shall be kept for every patient receiving emergency services and shall be incorporated in the patient's hospital record if such a record exists. The record shall

include:

a. Adequate patient information.
b. Information concerning the time of the patient's arrival, means of arrival and by whom transported.
c. Pertinent history of the injury or illness, including details relative to first aid or emergency care given prior to arrival at the hospital.
d. Description of the significant clinical, laboratory and roentgenologic findings.
e. Diagnosis.
f. Treatment given.
g. Condition of the patient on discharge or transfer.
h. Final disposition, including instructions given to the patient and/or his family relative to necessary follow-up care.

Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

18.5 The medical records of the Emergency Department shall be periodically reviewed by the Emergency Medicine Section, as well as any other pertinent Section.

18.6 Upon arrival at the reception window of the Emergency Department, the patient shall be asked whether prior arrangements have been made to meet a specific physician or if they would like a specific physician called. If not, patient shall be signed in to see the physician on duty. Such physician becomes the attending physician and is solely responsible for the disposition of the case.

18.7 The Executive Committee shall appoint a physician member of the Active Staff who is a resident of the immediate community to be the Director of the Emergency Department. The individual so named shall be responsible for scheduling full-time medical coverage by qualified physicians, all of whom shall be members of the Medical Staff and who will monitor the performance and practices of all persons in the Department. He/She will be responsible to the Executive Committee. The Executive Director and the Director of Nursing Services will appoint a registered nurse as supervisor for the Department who shall be responsible for monitoring all performance and practices in the Department and shall report to the Director of Emergency Department, the Director of Nursing Services and the Chief Executive Officer.

18.8 The Hospital shall contract with an independent group of physicians to provide 24-hours-a-day, 7-days-per-week primary physician coverage of the Emergency Department. Physicians who are members of such group and who devote the major portion of their medical practice to emergency care in the hospital shall be Active, Provisional Active, Courtesy, or Provisional Courtesy Staff members. Their staff appointments shall be made in the same manner as all other members of

the Active and Provisional Active Staff. Members of this contracting group shall be required to provide evidence of current certification in ACLS, ATLS and PALS, and to maintain these certifications. Any emergency exception to this requirement must be approved by the Chief of Staff. Evidence of this training will be maintained in the member's medical staff/credentials file. Physicians who are not members of such group and who work occasionally shall also satisfy the requirements for Medical Staff membership and be members of the Medical Staff.

18.9 The Director of the Emergency Department, the Chief of Emergency Medicine Section, and the Supervisor of the Emergency Department shall review the organization and procedures annually and report to the Executive Committee.

18.10 The Hospital will provide continuing education for hospital employees of the Emergency Department to refresh, update, and maintain skills of emergency services personnel to insure competent, up-to-date service. This will not be provided to physicians who provide service to the Hospital on a contract basis.

18.11 All suspected MI patients being directly admitted to special care units will be seen and evaluated by the Emergency Department Nurse. Initial treatment orders will be obtained from the Emergency Department Physician. If problems are noted by the nurse (e.g., arrhythmia, hypotension, or severe pain), the nurse will contact the patient's regular physician for further orders. If the physician cannot be contacted, or if the situation is deemed imminently life-threatening by the nurse, the patient will be evaluated and treated by the Emergency Department physician.

18.12 The physician designated as "on-call" for Emergency Department back-up in his specialty shall be responsible for emergency consultation anywhere in the hospital. The "on-call" physician, **OR** the properly credentialed physician extender under direct supervision of the physician, must respond to the hospital within thirty (30) minutes of being notified by hospital staff. The response may be in person or by telephone, and the treating ER physician will discuss the case with the "on-call" physician **OR** physician extender at that time. If the "on-call" physician determines that an additional consultation or referral is appropriate, the "on-call" physician is responsible for contacting the consultant, discussing the case with him, and ensuring the proper disposition of the patient for whom the "on-call" physician was initially consulted.

18.13 When a patient is admitted from the Emergency Department during the night, the attending physician shall see the patient no later than 10:00 a.m. the next day. It shall be the responsibility of the charge nurse of the unit to which the patient is admitted, to notify the attending physician of the patient's admission the following morning, or earlier should the patient's condition so warrant.

18.14 When a patient presents to the Emergency Department and needs admission, but has a primary physician who is not on staff at ODESSA REGIONAL MEDICAL CENTER, that primary physician shall be called about the patient. Should the primary physician want the patient admitted to the other acute care facility in Odessa, the patient will be transferred after the patient gives consent for the transfer, and it is determined by the ER Physician that the patient is stable.

18.15 Patients presenting to this facility who are sixteen (16) years or younger, and not pregnant, shall be considered as Pediatric Patients.

SECTION 19 PATIENT DEATH AND AUTOPSIES

19.1 In the event of a hospital death, the deceased patient shall be pronounced dead by the attending physician or his designee within a reasonable time after death. Hospital policies with respect to the release of dead bodies shall conform to local law.

19.2 It shall be the duty of staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist. The hospital pathologist will inform the attending physician where and when the autopsy will be performed so that they may attend. Provisional anatomic diagnosis shall be recorded in the medical record within 72 hours and the complete protocol should be made a part of the record within 60 days.

19.3 The attending physician will attempt to obtain a consent for an autopsy under conditions where the cause of death is in question or if there were unusual complications in the course of the patient's illness. Autopsies which are handled under the purview of the medical examiner's system may be conducted at an out-of-town site, and therefore it is not practical for the attending physician to be present at the time of autopsy. However, the physician's desire for specific feedback from the medical examiner will be transmitted with the autopsy request.

19.4 The Medical Staff will attempt to secure autopsies in deaths involving unusual causes, medico-legal issues, and educational interest, unless otherwise provided by law. Autopsy should be considered at least in the following circumstances:

1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
2. Deaths in which the cause is not known with certainty on clinical grounds.
3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death, and provide reassurance to them regarding the same.
4. Deaths in which an autopsy is requested by the immediate family of the deceased.
5. Death occurring in patients who have participated in clinical trials (protocols)

approved by the Institutional Review Board.

6. All Obstetric deaths.
7. Any unanticipated neonatal and pediatric deaths occurring not as a natural course of illness or condition.
8. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs.
9. Deaths known or suspected to have resulted from occupational or environmental hazards.
10. Sudden, unexpected, or unexplained deaths in the hospital which are apparently natural and not subject to a forensic medical jurisdiction.
11. Unexpected or unexplained death occurring during or following any dental, medical, or surgical diagnostic or therapeutic procedure.
12. Natural deaths that are ordinarily subject to a forensic jurisdiction such as the following:
    a. Persons dead on arrival at the hospital.
    b. Deaths occurring in the hospital within 24 hours of admission.
    c. Death of a patient who sustained an injury while hospitalized.
13. Deaths resulting from high-risk infections or contagious disease.

Results of autopsies will be used during the reappointment evaluation of a physician.

SECTION 20 ADVANCE DIRECTIVES / MEDICAL POWER OF ATTORNEY/ DNR

20.1 DNR Policies & Procedures, set forth in the Hospital Administration Manual, shall be adhered to by all members of the Medical Staff.

20.2 The procedures set forth in the referred to Policies & Procedures, shall be followed in all cases in which a patient has executed an Advance Directive and/or Medical Power of Attorney, and all other cases in which life support means are withheld or discontinued, even if there is no Advance Directive or Medical Power of Attorney.

20.3 These Policies and Procedures and all applicable Forms are made a part of these Rules and Regulations and are available in their entirety on Compliance 360.

SECTION 21 OBSERVATION OF PATIENTS

21.1 ADMISSION

If a patient is to be admitted as an Observation Patient, the minimal requirements for the History and Physical shall include Chief Complaint, Signs and Symptoms, Planned Course of Observation, and any significant changes to the patient's condition. The Emergency Room Face

Sheet or the Obstetric Triage Record (The Holister) may be utilized if the required information is recorded thereon. This information must be recorded within twenty-four (24) hours of admission as an Observation Patient.

21.2 **DISCHARGE**
At discharge, a Short Stay Summary or Discharge Progress Note must be recorded. This document must state any findings, final diagnosis, and final disposition of the patient. For the purpose of determining the length of stay, the time of discharge shall be deemed to be the time of the physician's order for discharge, whether verbal or written.

SECTION 22 OUTPATIENT SPECIAL PROCEDURES

22.1 Outpatient special procedures are defined as laser treatment and anesthetic blocks or injections. Pertinent note regarding diagnosis and services rendered is required on these patients.

SECTION 23 REQUIREMENTS FOR MODERATE SEDATION PRIVILEGES

23.1 Each applicant for Moderate Sedation Privileges must comply with the Criteria for Moderate Sedation

. 23.2 The criteria for applying are as follows:

CRITERIA

1. Practitioner must be a member in good standing of the Medical Staff at ODESSA REGIONAL MEDICAL CENTER (ORMC) with privileges in one of the recognized clinical departments.

2. The Medical Staff member must read and agree to abide by the ORMC Moderate Sedation Policy.

3. Medical Staff member must read the article "*Practice Guidelines for Sedation/Analgesia by non-Anesthesiologists"* which will be provided to the applicant as a handout.

   - Medical Staff member must take a written open book competency test and must have an 80 percent (80%) or better score in order to pass. May retake test at one (1) week intervals up to three (3) times. If all unsuccessful, must wait three months for re-test. Test material will be taken from the handout ***Recommendations for Administration of Sedation and Analgesia (Moderate Sedation) and Common Drugs Utilized for Moderate Sedation.*** Both articles will be provided to the applicant as a handout.

4. The Medical Staff Member must maintain current ACLS, ATLS, PALS, NRP, or Other Applicable Resuscitative Certification. (Specific to the age of patients treated.)

5. Moderate Sedation Privileges must be specifically requested with any other requested privileges at the time of reappointment.

23.3 **Exemptions:** Anesthesiologists/CRNAs

23.4 Moderate Sedation may be performed in the following designated areas:

Cath Lab	G.I. Lab	NICU	Surgery
Emergency Room	ICU	Radiology Department	

<u>SECTION 24</u> USE OF RESTRAINTS

24.1 The Restraints Policy, set forth in the Hospital's Patient Care Policy & Procedure Manual shall be adhered to by all members of the Medical Staff. This Policy and Procedure are made a part of the Rules & Regulations and is available in its entirety on Compliance 360.