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).**
Revised 09/28/10	**Section 4**	**Health Information Management; Paragraph 4.15 (revised wording for suspension rules enforcement that required changes for dictation of history and physicals and operative reports to be subject to automatic suspension and that automatic suspension shall be applicable to admitting privileges).**
Revised 09/28/10	**Section 18**	**Emergency Services; Paragraphs 18.1-18.16 (revised wording for compliance with EMTLA regulations including deletion of Paragraph 18.13)**
Revised 11/23/10	**Section 4**	**Health Information Management; Paragraph 4.15 (revised wording for clarification of suspension rules enforcement applicable to the reading and dictation of EKGs, EEGs,**

		Echocardiograms, Vascular ultrasounds such as Carotids, Arterial, Venous, and Transesophageal Echocardiograms as well as Holter and ambulatory blood pressure Monitors within 48 hours).
Revised 07/24/12	**Section 11**	**Surgery Rules; Paragraph 11.5, Anesthesia (revised wording for compliance with CMS Anesthesia Services Interpretive Guidelines and DNV accreditation standards)**
Revised 09/25/12	**Section 11**	**Surgery Rules; Paragraph 11.5, Anesthesia (revised wording for additional change to account for Podiatrists and Dentists related to general anesthesia.**
Revised 03/26/13	**Section 4**	**Health Information Management; Paragraph 4.15, Other Automatic Suspensions (added provision for repeated suspensions)**
Revised 03/26/13	**Section 11**	**Surgery Rules; Paragraph 11.5, Anesthesia (revised wording for compliance with CMS Anesthesia Services Interpretive Guidelines and DNV accreditation standards relating to the type and complexity of procedures that an operating practitioner can supervise)**
Revised 03/26/13	**Section 20**	**Advanced Directives / Medical Power of Attorney / DNR; Paragraph 20.3 (revised wording to replace policy and procedure repository Compliance 360 with current repository, IASIS Repository for Electronic Policies and Procedures)**
Revised 03/26/13	**Section 24**	**Use of Restraints; Paragraph 24.1 (revised wording to replace policy and procedure repository Compliance 360 with current repository, IASIS Repository for Electronic Policies and Procedures)**
Revised 06/25/13	**Section 11**	**Surgery Rules; Paragraph 11.5, Anesthesia (revised wording for compliance with CMS Anesthesia Services Interpretive Guidelines and DNV accreditation standards)**
Revised 11/19/13	**Section 3**	**Orders for Treatment; Added Paragraph 3.7 (inserted provision for physician certification orders due to new CMS certification requirements)**
Revised 11/19/13	**Section 4**	**Health Information Management; Paragraph 4.2 (revised wording to specify that history and physical examinations are to be authenticated, timed, and dated prior to discharge and to delete reference to short stay summary in response to new CMS certification requirements)**
Revised 11/19/13	**Section 4**	**Health Information Management; Paragraph 4.15 (revised wording to delete reference to short stay summary and reword timeframe for dictation in response to new CMS certification requirements)**
Revised 11/19/13	**Section 21**	**Observation of Patients; Paragraph 21.2; Discharge (revised wording to delete reference to short stay summary in response to new CMS certification requirements)**
Revised 8/22/15	**Section 4**	**Health Information Management; Paragraph 4.15 Automatic Suspension (revised timeframe for completion of discharge summaries, death summaries and history & physicals to 24 hours to be successful and in compliance with ICD-10 guidelines)**
Revised 4/25/17	**Section 2**	**Physician Responsibilities; Paragraph 2.8, (revised wording in accordance with Texas law which requires wearing photo identification in the hospital)**

Revised 4/25/17	**Section 3**	**Orders for Treatment; Paragraph 3.1, (revised wording in accordance with Texas law which now allows for verbal and telephone orders shall be dated, timed, and authenticated within 96 hours)**
Revised 4/25/17	**Section 4**	**Health Information Management; Paragraph 4.2, Admission History, (requirements for admission, history and physical examinations moved to Medical Staff Bylaws, Article III, Medical Staff Membership, Section 3.3(q) in accordance with accreditation standards**
		Health Information Management; Paragraph 4.5, Consultations, (revised wording in accordance with accreditation standards)
		Health Information Management; Paragraph 4.9, Discharge Summary, (add additional required elements of discharge summary and to change required time frame for summaries to be completed from within 48 hours to within 24 hours of discharge)
		Health Information Management; Paragraph 4.15, Other automatic suspensions, (add automatic suspension for non-compliant query responses)
Revised 4/25/17	**Section 7**	**Diagnostic Exams / Procedures: Laboratory, Radiology, Cardiology, Respiratory Therapy; Paragraph 7.2, modify in accordance with accreditation standards**
Revised 4/25/17	**Section 12**	**The Section of Obstetrics and Gynecology, Guidelines for Family Physician Doing Obstetrics; Paragraph 12.2, (correction from Family Practice to Family Medicine Residency**
Revised 4/25/17	**Section 17**	**Section of Emergency Medicine Privileging and Credentialing, Paragraph 17.2, (correction from Family Practice to Family Medicine**

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 required to wear some form of visible photo identification which denotes their status at ORMC. 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 96 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.

3.7 Physician certification orders are to be authenticated, dated, and timed the day of admission.

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 Admission History

The requirements for admission, history and physical examinations are as outlined in the Medical Staff Bylaws, Article III, Medical Staff Membership, Section 3.3(q).[a]

[a] CMS requires that the Bylaws include the requirement for timing of the history and physical examination (42 C.F.R. §482.22(c)(5)). DNV MS.17, SR.1 also requires that the bylaws include the requirement for timing of the history and physical.

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.

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**[b]

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician.[c] The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. Providers who are consulting are to visit the patient within 24 hours of the consult and dictate a consult note.

[b] DNV MS.18 requires that the Medical Staff define in its bylaws the circumstances and criteria under which consultation or management by a physician or other qualified licensed independent practitioner is required.

[c] The idea behind this provision is facilitating communication between the Attending Physician and the Consulting Physician in order to provide for continuity of care. This requirement ensures that there is initial communication to request the consultation, acceptance of consultation, and accountability for the occurrence of the consultation itself.

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;
- Outcome of the hospitalization treatment, procedures, or surgery;
- Final diagnosis; and
- Disposition of the patient and provisions for follow-up care.

All summaries shall be completed within 24 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 within thirty (30) days of discharge. Discharge summaries shall be dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetric deliveries and normal newborn infants. Operative reports are required to be dictated immediately after the procedure. If the operative report is not dictated within 12 hours of the end of an invasive procedure requiring such report, the physician shall be notified that admitting privileges will be suspended unless the report is dictated within 24 hours. A fax and telephone call will be placed to the physician informing him/her that failure to dictate the operative report by specified date/time will result in automatic suspension of admitting privileges.

Other automatic suspensions:

Discharge summary and death summary within 24 hours of discharge. History & Physical not dictated within 24 hours or prior to discharge will result in an automatic suspension. Noncompliance will result in automatic suspension of admitting 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 telephone call that his/her medical staff admitting privileges shall be automatically suspended if records are not completed by 7:00pm every 2nd and 4th Wednesday of the month. Notices of incomplete and delinquent medical records will be sent on the 1st and 3rd Wednesday of each month. At the end of the notice period, if the medical record still remains incomplete, all admitting 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.

Emergency Department records, EKG, EEG, and Echocardiogram, Vascular Ultrasound, and Holter and ambulatory blood pressure Monitor readings are considered medical records for purposes of this Section. EKGs, EEGs, Echocardiograms, Vascular ultrasounds such as Carotids, Arterial, Venous, and Transesophageal Echocardiograms as well as Holter and ambulatory blood pressure Monitors must be read and dictated within 48 hours of the date on which the EKG, EEG, Echocardiogram, Vascular ultrasound such as Carotids, Arterial, Venous, and Transesophageal Echocardiogram as well as Holter and ambulatory blood pressure Monitor is placed in the physician's box. Three failures 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 of admitting privileges.

Physician queries are to be answered within 48 hours of being placed in the medical record. Failure to answer query within 48 hours will result in automatic suspension of admitting privileges. If and when the Provider has acquired 5 non-compliant query responses, he/she will be required to report to meet with the Medical Staff Executive Committee.

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 Emergency Room, Admitting, and Operating Room departments.

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 Medical Staff Executive Committee. The delinquent practitioner, upon receipt of notice, will meet with the Medical Staff Executive

Committee 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 Medical Staff Executive Committee, should obtain one (1) additional suspension, this will result 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.

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 not permitted.

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 (and patients may be referred for hospital outpatient services) by a practitioner who is: Responsible for the care of the patient;

- Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient;
- Acting within his/her scope of practice under State law; and
- Authorized by the medical staff to order the applicable outpatient services under a written hospital policy that is approved by the governing body. This includes both practitioners who are on the hospital medical staff and who hold medical staff privileges that include ordering the services, as well as other practitioners who are not on the hospital medical staff, but who satisfy the hospital's policies for ordering applicable outpatient services and for referring patients for hospital outpatient services

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 ANESTHESIA

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (including deep sedation), regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

11.5(a) Anesthesia services throughout the hospital shall be organized into one anesthesia service under the direction of a qualified physician. The chief of anesthesia services shall be selected by the Governing Board in consultation with the Medical Executive Committee and Chief of Staff and shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. Factors which shall be considered among the qualifications for the position of chief of anesthesia services include but are not limited to current or previous exercise of privileges to administer anesthesia at the hospital; training in anesthesia services; experience in supervising CRNAs or other practitioners in the administration of anesthesia; ACLS, ATLS, or other resuscitative certification; and the completion of continuing medical education relevant to anesthesia services. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.

11.5(b) The hospital shall maintain policies and procedures governing anesthesia services provided in all hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized

guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

11.5(c) Only credentialed and qualified individuals as defined in the policies and procedures of the hospital may provide anesthesia services. The Department of Surgery shall approve credentialing guidelines consistent with federal regulations and DNV standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the hospital. CRNAs administering analgesia, including epidural analgesia for the purpose of labor and delivery, may do so without supervision. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care must be supervised either by the operating practitioner who is performing the procedure or by an anesthesiologist.[d] The supervising practitioner must be immediately available when anesthesia is administered. A practitioner is considered "immediately available" only if he/she is physically located within the same area and or department, as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

When supervision of CRNA administered anesthesia services by a practitioner other than an anesthesiologist is required, the operating practitioner who is a doctor of medicine or osteopathy shall supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care, including epidural anesthesia (surgical epidurals), for any and all such procedures for which the operating practitioner has privileges. The operating practitioner who is a dentist, oral surgeon, or podiatrist and who is qualified to administer anesthesia under state law shall supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia and monitored anesthesia care, including epidural anesthesia (surgical epidurals), for any and all such procedures for which the operating practitioner has privileges. For the purpose of this Section 11.5(c), when a labor is converted to Caesarean section, administration of an epidural from that point forward is considered epidural anesthesia, and a CRNA administering such an epidural must be supervised as described herein.

11.5(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the hospital. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, this record shall include a pre-anesthesia evaluation, an intraoperative record, and a post-anesthesia evaluation.

[d] CMS regulations permit states to exempt hospitals within their jurisdiction from the CRNA supervision requirement upon meeting specified regulatory requirements. See 42 CFR § 482.52(c). As of October 2010, the following states have opted out of the CRNA supervision requirement: Alaska, California, Colorado, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington, and Wisconsin. If the hospital is located in a state that has opted out of the CRNA supervision requirement, then the hospital may permit a CRNA to administer anesthesia without operating practitioner or anesthesiologist supervision.

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by CMS and DNV.

The individual who administered the patient's anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital, must also perform a postanesthesia evaluation of the patient and document the results of the evaluation no later than forty-eight (48) hours after the patient's surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than forty-eight (48) hours, as addressed in hospital policies and procedures. For those patients who are unable to participate in the postanesthesia evaluation, a postanesthesia evaluation should be completed and documented within forty-eight (48) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

11.5(e) The anesthetist or anesthesiologist will be responsible to obtain and document informed consent for anesthesia in the medical record. In order to ascertain the patient's wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the Attending Physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

11.5(f) The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the qualified anesthesia provider must not exceed twenty (20) minutes.

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 Medicine 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) <u>Medical Problems Relating to Pregnancy</u>

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) <u>Obstetrical Complications</u>

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) Previous Caesarean Section

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.

SECTION 13 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 Medicine, 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 Medicine 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 Medicine 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.

SECTION 18 EMERGENCY SERVICES

18.1 Emergency services are those medical services rendered which include assessment, stabilization and treatment of persons presenting with emergency medical conditions and may include services provided by ancillary departments.

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

18.3 All persons presenting to the Emergency Department shall have an appropriate medical screening exam to determine if an emergency medical condition exists (as defined by Federal Law) 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. Emergency Department
A physician or designated mid-level provider will perform the MSE.

B. Labor and Delivery (L&D)
The QMP is the Registered Nurse in L&D and the diagnosis of false labor must be certified 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. Emergency care, treatment and services provided to the patient prior to arrival, if any;
b. Information concerning the time of the patient's arrival, means of arrival and by whom transported. EMS documentation will be kept with the medical record;
c. Documentation and findings of assessments;
d. Conclusions or impressions drawn from medical history and physical findings.
e. Diagnosis, diagnostic impression or conditions;
f. Diagnostic and therapeutic orders;
g. Diagnostic and therapeutic procedures, tests, and results;
h. Response to care, treatment, and services provided;
i. Allergies to foods and medications;
j. Every medication ordered or prescribed;
k. Medication reconciliation completed;
l. Condition of the patient on discharge or transfer;
m. Final disposition, including instructions given to the patient and/or his family relative to follow-up care, including prescriptions given;
n. Any referrals made to other care provides, community agencies, or reporting authorities.

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 pertinent Section.

18.6 Upon signing in for emergency services, the patient will be asked whether prior arrangements have been made to meet or contact a specific physician. If not, patient will be seen by the ED provider / physician on duty and that physician becomes solely responsible for the disposition of the case. If the primary physician has indicated as a preference to be called on all his patients prior to or after seen by the ED provider, that will be honored.

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 Medical 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 Chief Executive Director and the Chief Nursing Officer will appoint a registered nurse as Director of Emergency and Trauma Services, who shall be responsible for monitoring all performance and practices in the Department and shall report to the Medical Director of Emergency Department, the Chief Executive Officer and the Chief Nursing Officer.

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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 Medical Director of the Emergency Department, the Chief of Emergency Medicine Section, and the Director of the Emergency and Trauma Services shall review the policies 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.

18.11 All patients being directly admitted, that arrive in an unstable life–threatening condition will be registered and stabilized in the Emergency Department until the admitting physician can be notified.

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 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 Emergency Department physician will discuss the case with the "on-call" physician. 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. The Emergency Department physician has the ultimate authority in deciding whether the "on-call" physician needs to come to the hospital to help stabilize the patient.

18.13 When a patient presents to the Emergency Department to be seen and their primary physician does not have admitting privileges at ***ODESSA REGIONAL MEDICAL CENTER*** and the patient requests that physician be notified, the ED staff will contact said physician and obtain any pertinent information to promote continuity of care for 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. A stabilized patient may request a transfer to another facility if the reasons and request is in writing, the patient has been informed of the risks and benefits of the transfer, the receiving hospital has the capacity and ability to care for patient and has accepted the patient, the receiving physician has accepted the patient, and appropriate arrangements for the patient transfer have been met. Copies of all medical records will be sent with the patient.

18.14 Patients presenting to this facility who are seventeen (17) years or younger, and not pregnant, shall be considered as Pediatric Patients. The unit or floor the patient is admitted to will be at the discretion of the pediatrician.

18.16 The Emergency Department physician on duty is responsible for the general care of all patients presenting to the Emergency Department and the responsibility remains with the ED physician until the patient's private physician or an on-call specialist assumes the responsibility or the patient is discharged.

<u>SECTION 19</u> 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 in IASIS Repository for Electronic Policies and Procedures.

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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 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	

SECTION 24 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 in IASIS Repository for Electronic Policies and Procedures.