



Texas Health
Harris Methodist Hospital
SOUTHLAKE

Please review the Medical Staff Bylaws, Rules & Regulations,
Orientation Handbook and Medical Staff Policies located on
the Texas Health Harris Methodist Hospital Southlake web site:

www.texashealthsouthlake.com

under

Join Our Team

Medical Staff Services.

CareConnect/EPIC Training

Texas Health Resources' Electronic Medical Record is known as CareConnect/EPIC. Prior to providing patient care, you are required to complete instructor-led training at any Texas Health facility. If you have received CareConnect training, but have not provided patient care at a THR facility (and documented via CareConnect) in the past six months, a refresher course is required prior to providing patient care at Texas Health Southlake (THSL).

THSL provides one-on-one training between the hours of 7:30AM – 3:30PM on Mondays, Thursdays and Fridays. Please contact our Physician Training & Support Team at 817-748-8800 at least two weeks prior to your scheduled cases to arrange for your training.

(Current/Competent) I was CareConnect/EPIC Trained at _____ Facility and have a completed/documented case/s in CareConnect in the past 6 months and will not need any assistance. I am competent with the system.

(Refresher Requested) I was CareConnect/EPIC Trained at _____, but have not completed/documented a case/s in CareConnect in the past 6 months therefore require a refresher course and will call Physician Training & Support Team at 817-748-8800 to schedule 2 weeks prior to my Southlake Case.

(Full Training Requested) I require CareConnect/EPIC training and will call Physician Training & Support Team at 817-748-8800 to schedule 2 weeks prior to my Southlake Case.

Signature: _____



ACKNOWLEDGMENT

PHYSICIANS:

I have received a copy of the **MEDICAL STAFF BYLAWS, RULES & REGULATIONS** and **ORIENTATION HANDBOOK**.

Signature: _____

Please print name: _____

Date: _____

ALLIED HEALTH:

I have received a copy of the **ALLIED HEALTH MANUAL, MEDICAL STAFF BYLAWS** and **ORIENTATION HANDBOOK**.

Signature: _____

Please print name: _____

Date: _____

Medical Staff/Allied Health TB Screening Questionnaire

You have indicated that you cannot take the TB skin test (TST) for one of the following reasons. Please complete this questionnaire carefully and return or fax to 817-748-8816. If you choose to fax this form, always call (817-748-8782) and confirm that it was received.

Name: _____ Department: _____

1. I am unable to have a TB skin test because I have a/an:
 - ⇒ History of a positive TB skin test (PPD)
If history of positive TB skin test - Check one of the following:
 - ⇒ I was treated with medication
 - ⇒ I was not treated with medication
 - ⇒ Allergic (anaphylactic) reaction to TB skin test (PPD)
 - ⇒ Medical condition that prevents me from taking the TB skin test (PPD)

Explain: _____

Check any signs & symptoms that you are having:

- Recurrent night sweats
- Coughing up blood
- Unexplained weight loss
- Persistent cough greater than 2 weeks not due to any other medical condition
- Unexplained fever
- Abnormal chest X-ray with indication of possible TB (need documented proof)

2. ⇒ **YES**, I am experiencing the above signs and symptoms.
If you checked any of the signs and symptoms above, you must be evaluated by the Employee Health Nurse immediately. Please call 817-748-8752.
3. ⇒ **No**, I am not experiencing any of the above symptoms.

SS#	Birth date:
Address:	Phone:
City:	Zip Code
Signature:	Date:

For Office use only:

Evaluated: ___yes (date _____) ___no

Outcome of evaluation:



MEDICAL RECORDS SIGNATURE SHEET

Printed Name: _____

Signature: _____

Initials: _____

Service Area: _____

Date: _____

TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHLAKE

MEDICARE/MEDICAID ATTESTATION

The following is an extract from the Federal Register (Catalogue of Federal Domestic Assistance Program No. 93.773, Medicare-Hospital Insurance; and Program No. 93.774, Medicare-Supplementary Medical Insurance Program):

“Notice to Physicians”

Medicare/Medicaid payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I have read the above notice:

Physician Signature

Date

The above statement will be retained as required for as long as you hold medical staff privileges at Texas Health Harris Methodist Hospital Southlake.

CALL COVERAGE FORM:

NAME (PLEASE PRINT OR TYPE)

SPECIALTY/SUBSPECIALTY

The Medical Staff Bylaws state that **each member** of the Medical Staff must arrange for patient coverage in the event that the physician is unavailable for the medical management of a patient. Please complete this form in order to document the name and acknowledgment of a currently credentialed physician who will provide coverage in this event.

THIS FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN WHO IS CURRENTLY A MEMBER OF THE MEDICAL STAFF AND PRACTICES IN THE SPECIALTY/SUBSPECIALTY IN WHICH YOU HAVE REQUESTED PRIVILEGES. NO EXCEPTIONS!

I agree to provide patient coverage for the above named physician at Texas Health Harris Methodist Hospital Southlake in the event that such physician is unavailable for the medical management of his/her patient.

COVERING NAME (PLEASE PRINT OR TYPE)

COVERING SIGNATURE

COVERING SPECIALTY/SUBSPECIALTY

DATE

COMPLIANCE PROGRAM ACKNOWLEDGMENT STATEMENT

I, _____, hereby acknowledge that I have been made aware of the Compliance program and its purpose and intent. I understand that my participation in or lack of is critical to the overall success of **Texas Health Harris Methodist Hospital Southlake** and its strategic goals. It is further understood that I will abide by all policies and procedures set forth.

Secondly, I have received a copy of the Standards of Conduct and will abide by them and utilize them as they relate to the provision of care to the patients of Texas Health Harris Methodist Hospital Southlake.

Finally, it is understood that any violation of compliance policies and procedures may adversely affect my medical staff privileges.

Practitioner Signature

Date

Practitioner Name (Print)

STANDARDS OF CONDUCT are located under **PHYSICIAN COMPLIANCE** on the Texas Health Harris Methodist Hospital Southlake web site: www.texashealthsouthlake.com under Medical Staff Services.

Surgeon Designation Form for Anesthesiologists

Due to the significant number of requests for applications for anesthesiology privileges, the Medical Executive Committee of Texas Health Harris Methodist Hospital Southlake has recommended that all anesthesiologists applying to this medical staff be required to designate a surgeon or surgeons for whose patients you will be providing care. Please complete this form and submit it with your application. Your application will be prioritized according to the date it is submitted plus whether the surgeon you designate is also applying or has been approved for medical staff membership at Texas Health Harris Methodist Hospital Southlake.

Reminder: The surgeon(s) you designate must be on the Medical Staff at Texas Health Harris Methodist Hospital Southlake or must be in the application process. Please list only those surgeons you currently work with or those who have specifically asked that you apply. The information you submit will be verified.

□ □ □ □ □ □

Name of surgeon(s) you are designating as the surgeon you will be working with at Texas Health Harris Methodist Hospital Southlake:

□ □ □ □ □ □

Name of surgeon(s) who have specifically requested that you apply for privileges at Texas Health Harris Methodist Hospital Southlake:

**TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHLAKE
MEDICAL STAFF POLICY:
MANAGEMENT OF THE DISRUPTIVE PRACTITIONER**

Refusal to Cooperate

A Member's failure to appear for counseling or refusal to take any required action or to cooperate with the recommendation of any Medical Staff Committee, may result in automatic relinquishment of Medical Staff Membership and Privileges.

ACKNOWLEDGMENT

I have received and read a copy of the policy regarding management of the disruptive practitioner and agree to abide by this policy at all times.

If at any time I feel as if I am impaired physically or emotionally I will self refer myself to the Medical Staff Behavioral Event Review Committee or the appropriate health care professional or agency for evaluation and/or treatment.

(Note: Presence of this signed statement in the Practitioner's Medical Staff credentials file is required prior to any favorable action by the Board of Trustees on the Practitioner's application or re-application. Refusal to sign this statement does not exonerate any practitioner from abiding to the Medical Staff Bylaws, Rules & Regulations or any Texas Health Harris Methodist Hospital Southlake hospital policies.)

Signature _____

Date _____

Please Print Name _____

Disruptive Practitioner Policy is located under **MEDICAL STAFF POLICIES** on the Texas Health Harris Methodist Hospital Southlake web site: www.texashealthsouthlake.com under Medical Staff Services

COMPUTER KEY SIGNATURE AUTHENTICATION

This is to verify that I have and shall be using, for the purpose of authentication of my medical records:

- A computer key, which will be used by no one other than me

By signing below, I attest that I will maintain a secure PIN number, and will be the only individual to use the PIN number. I will not delegate the use of the computerized signature to any other person or person(s).

Signature

Date

**FACT SHEET FOR PHYSICIANS OR OTHER AUTHORIZED LICENSED INDEPENDENT PRACTITIONERS
ON RESTRAINT & SECLUSION**

Dear Physician or LIP:

You are authorized by your scope of practice, and privileges granted by the medical staff, to order the use of restraint or seclusion. Your signature below indicates that you have reviewed and understand the organization's policy regarding the care and management of patients placed in restraint or seclusion. Key policy requirements are reiterated as follows:

Policy Statement & Patient Rights

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a convenience, or retaliation by staff.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

The organization will work to actively decrease the use of restraint or seclusion. When restraint or seclusion is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well being. The use of restraint/seclusion is a last resort, after alternative interventions have either been considered or attempted.

Prohibitions to Use of Restraint or Seclusion

The use of restraint or seclusion for the following reasons is strictly prohibited:

- Use that is based solely on a patient's prior history and/or behavior.
- Use as a convenience to staff.
- Use as a method of coercion or as punishment.

Requirements for Patient Assessment & Ordering of Restraint or Seclusion

The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Each order for restraint or seclusion must contain at least the following information:

- The name of the patient being restrained or placed into seclusion
- The date and time of the order
- The name of the LIP ordering the restraint or seclusion
- The type of restraint or seclusion to be applied
- The time limit (duration) of the restraint or seclusion

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order.

The initial order for medical restraint must be time limited and shall not exceed 24 hours. Renewal orders for restraint shall be obtained at least once each calendar day. Renewal orders shall be based on an examination of the patient by an LIP.

Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be ordered / renewed in accordance with the following limits for up to a total of 24 hours:

- Four (4) hours for adults age 18 and older;
- Two (2) hours for children and adolescents ages 9 to 17;
- One (1) hour for patients under age 9.

After 24 hours, before writing a new order a physician or other LIP who is responsible for the care of the patient must see and assess the patient. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a Physician or other LIP; or RN or PA who has been trained in accordance with the requirements of this policy. The purpose of the face-to-face evaluation is to assess; the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.

Signature of Physician or Other LIP

Date

INFECTION PREVENTION PHYSICIAN/ LIP EDUCATION: National Patient Safety Goals

Our facility is dedicated to promoting Patient Safety. The Joint Commission’s National Patient Safety Goals (NPSGs) and related initiatives are designed to promote improvements in patient safety and reduce the risk of healthcare associated infections. This includes hand hygiene, preventing transmission of multidrug resistant organisms, central line associated bloodstream infections, surgical site infections, catheter associated urinary tract infections and ventilator associated pneumonias. In order to comply with required education, please review the information below and implement these infection prevention measures.

Preventing Multidrug Resistant Organisms (MDROs): Hand hygiene, appropriate personal protective equipment (follow standard & contact precautions), control antibiotic use (Antibiotic Stewardship), and handwashing with soap and water for at least 15 seconds when caring for Clostridium difficile (spores are not destroyed by alcohol hand rubs)

Preventing Central Line-Associated Bloodstream Infections (CLABSIs): Hand hygiene performed by all staff prior to insertion, use of a checklist at the time of insertion required by TJC, hand hygiene performed by all staff prior to insertion, use a product with 2% chlorhexidine (CHG)/70% alcohol to prep the skin and allow to air dry, use the preferred subclavian site for non-PICC central lines (avoid femoral site when possible), maximal barriers for line insertion (masks worn by everyone in room, head covering, sterile gown, and sterile gloves worn by person(s) inserting the line, full body drape for the patient), daily assessment of line necessity, physicians please remove lines that are no longer needed, and prevent introduction of germs when accessing lines.....**SCRUB the HUB for at least 15 seconds!** Use CHG impregnated disc.

Preventing Surgical Site Infections (SSIs): Preoperative bathing (chlorhexidine gluconate) to reduce skin microbes, adequate antimicrobial skin prep to surgical site, meticulous hand hygiene for all caregivers, cleaning of surgical suite, equipment, and surgical instruments according to established guidelines, aseptic technique and gentle tissue handling during the procedure and with postoperative wound management, hair removal by clipping (no shaving), control of blood glucose levels during immediate postoperative wound management, maintenance of normothermia (normal body temperatures) during colorectal surgery, smoking cessation (smoking interferes with normal wound healing), choice of an antimicrobial agent according to established guidelines, administration of the antimicrobial agent within one hour before incision (with exception of Vancomycin), discontinuation of prophylactic antimicrobial agent within 24 hours after surgery (in most cases)

Preventing Catheter-Associated Urinary Tract Infections (CAUTIs): Use urinary catheters only when indicated (acute urinary retention or bladder outlet obstruction, need for accurate measurements of urinary output in critically ill patients), perioperative use for selected surgical procedures (urologic surgery or other surgery on contiguous structures of the genitourinary tract, anticipated prolonged duration of surgery then removed in PACU; when used for this reason, patient will receive large volume infusions or diuretics during surgery, and intraoperative monitoring of urinary output). Other appropriate uses include assistance in healing open sacral or perineal wounds in incontinent patients, prolonged immobilization, and hospice or palliative care.

initial/date



Fight CRBSIs!
Use BIOPATCH® Every Single Time.

How to apply BioPatch® Disk:

- 1 Prepare the insertion site. Secure catheter at least 1" (2.5cm) from insertion site.
- 2 Ensure skin prep is completely dry. Place BioPatch® around catheter printed side up.
- 3 Align catheter with radial slit. Ensure edges of slit touch.
- 4 Secure catheter and BioPatch® with transparent film dressing. Ensure complete contact between BioPatch® and skin.

How to remove BioPatch®:

- 1 Peel film away from catheter.
- 2 BioPatch® comes away with film.

Preventing Ventilator-Associated Pneumonias (VAPs): Hand hygiene, head of bed elevated 30-45 degrees, oral care protocol, sedation vacation.

Orientation Handbook Acknowledgement

By signature indicated below, I certify that I have read and reviewed the Texas Health Southlake General Hospital Orientation Handbook for Medical Staff, Allied Health and Employees. I understand the contents of said handbook and agree to comply with all that is written. I acknowledge that the following information was included in the Orientation Manual.

- ✚ Compliance Program Standards of Conduct
- ✚ Return of Company Property
- ✚ Quality/Risk Management
- ✚ HIPAA/Compliance
- ✚ National Patient Safety Goals
- ✚ Confidentiality & Information Systems Use
- ✚ Confidentiality Agreement
- ✚ Diversity & Inclusion
- ✚ Mission, Vision and Values
- ✚ Infection Prevention
- ✚ Employee Health
- ✚ OSHA
- ✚ Patient Rights & Organizational Ethics
- ✚ Environment of Care
- ✚ Safety/Security - I am aware of steps to take in the emergency or situations and communication contact to manager and/or Safety Officer.
- ✚ I am aware the Medical Staff Bylaws, Rules & Regulations, the Allied Health Manual and Policies are located on the Texas Health Southlake web site: www.texashealthsouthlake.com Under Join Our Team; Medical Staff Resources

Please note that the Medical Staff and the Governing Board of the hospital have the ability to update the Medical Staff Bylaws, Rules & Regulations, the Allied Health Manual and Policies.

Signature

Date

Printed Name