Texas Health
Harris Methodist Hospital
SOUTHLAKE

MEDICAL STAFF
RULES AND REGULATIONS

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Approved by the Medical Staff and Board of Managers – February 21, 2018

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I. INTRODUCTION

These Rules and Regulations are established by and for the Medical Staff of Texas Health Harris Methodist Southlake under the authority of the Medical Staff Bylaws.

For clarity and ease of reading, “Practitioner, Physician and Member” are referred to the male gender although they may be either male or female. In addition, all references to “he/him/his” throughout shall refer to both males and females.

II. ADMISSION AND DISCHARGE

1. Patients shall be admitted to the hospital only upon orders of a Member of the Medical Staff.

2. A physician member of the medical staff shall be responsible for the care and treatment of each patient in the hospital. All patients shall have a complete history and physical performed and recorded in the medical record by a physician who is either a member of the medical staff or has been approved by the medical staff to do so. Dentists and podiatrists shall be responsible for recording in the medical record a history and physical examination relative to the dental or podiatric problem. Any medical problem present on admission or arising during the hospitalization of a dental or podiatric patient shall become the responsibility of a qualified physician.

3. Except as otherwise provided in hospital policies for utilization of beds, no patient shall be transferred within the hospital without the approval of the responsible practitioner, with the exception of a patient who needs immediate relocation to protect himself or others. In the latter case, the Chief of Staff shall be contacted to approve any move if the responsible physician is not available. The responsible practitioner shall be notified as soon as he can be reached.

4. All inpatients shall be visited by their attending practitioner or designee with appropriate privileges at least once every 24 hours and this shall be documented in the medical record. If an absence of more than 24 hours is contemplated, the attending practitioner shall arrange for another qualified member of the medical staff to attend the patient. and the nursing stall shall be notified of the name of the practitioner who shall be responsible in the interim.

5. When a patient is being transferred to another hospital, a nursing home, or other health care facility, the responsible practitioner or other individual authorized by hospital policy shall indicate the reason for transfer, the name of the receiving facility, the name of the accepting practitioner, and the status of the patient's stability and shall sign the inter-facility transfer documents.

6. The Patients shall be discharged only on the order of the responsible practitioner or in accordance with approved discharge criteria. If a patient leaves the hospital against medical advice (AMA), the patient or his/her legally responsible representative shall be requested to sign a hospital approved AMA release statement. If an AMA release statement cannot be obtained such must be noted in the patient's medical record along with an explanation for why it could not be obtained. A patient leaving the hospital on his own accord AMA shall be considered to be deemed discharged.

7. When a transportable patient requires medical staff consultation/treatment not available, the patient shall be transferred to an appropriate facility as soon as possible, subject to compliance with the hospital's transfer protocol, regulatory requirements, and subject to having first obtained acceptance by that facility through a physician or other qualified health care provider.

8. If a patient of a podiatrist is admitted to inpatient status or is assigned to outpatient or observation status, a doctor of medicine or a doctor of osteopathy shall assume responsibility for the care of any medical problem or condition of the patient that may exist at the time of the admission or that may arise during the hospitalization and that is beyond the scope of a podiatrist’s license or privileges.

III. MEDICAL RECORDS

A. History and Physical

1. All practitioners are to document a complete medical history and physical examination (H & P) for all patients not later than 24 hours after admission but prior to surgery or any procedure requiring General anesthesia or moderate sedation. If a complete H & P has been recorded within 30 days prior to admission or surgery a durable legible copy of this report in a form approved by the Medical Staff and performed by a Member of the Medical Staff, may be used in the medical record for the current admission or surgery. The H & P must be updated not later than 24 hours after admission but prior to surgery, by documenting no significant changes or listing changes in the patient's condition.

2. A dentist or podiatrist may perform the part of the history and physical examination related to the specialty problem justifying the reason for admission.

3. If a medical history and physical examination is performed by a non-licensed provider, the medical history and physical exam must be validated and countersigned by an Independent Licensed Practitioner within 24 hours.

4. A complete history shall address:
   - a present illness
   - pertinent past family and social history
   - review of symptoms

   Variance within these areas is allowed depending on the setting, level of care, treatment and services needed and/or provided.

5. A complete physical examination shall address major body systems with an emphasis on areas pertinent to the present illness but variation is allowed depending on the setting, level of care, treatment and services needed and/or provided.

6. In cases where a complete history and physical is not present in the medical record, the clinical nurse shall request the admitting physician or if unavailable the surgeon to record a pertinent handwritten history and physical in the medical record prior to the induction of anesthesia, unless an emergency situation exists.

7. Elective inpatient or outpatient surgery is subject to delay or cancellation until a pertinent history and physical examination is recorded in the medical record.

B. Documentation for Consultations

1. Consultants shall document communication with the patient's attending physician and/or review of the patient's record by the consultant.

2. Pertinent findings on examination and the consultant's assessments, opinion and recommendations must be noted.

3. A limited statement such as “I concur” does not constitute an acceptable report of consultation.

C. Progress Notes

1. The progress notes should provide a chronological report of the patient's course in the hospital and should reflect any material change in condition and the results of treatment.

2. The patient's clinical problems should be clearly identified and correlated with an assessment and plan.

3. Progress notes shall be written at least daily and more often when warranted by the patient’s condition.

4. Progress notes shall be legible, dated, timed and signed.

D. Surgical Records

1. A preoperative diagnosis is recorded prior to surgery.

2. If a complete operative report is not placed in the medical record immediately after surgery, a post-operative progress note, comprehensive enough to permit continuity of care, must be entered in the medical record at the time of completion of the procedure and prior to the patient going to the next level of care. The post-operative progress note shall include the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure, findings, complications (if any), estimated blood loss, specimens removed, and postoperative diagnosis.

3. Complete operative reports must be dictated in the medical record within 24 hours after surgery and shall contain:
   - The name of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
   - The name of the procedure(s) performed;
   - A description of the procedure
   - Findings of the procedure
   - Any estimated blood loss
   - Any specimens removed
   - Complications, if any
   - The postoperative diagnosis.

4. The completed operative report by the performing practitioner shall be placed in the medical record as soon as possible after surgery.

5. The following immediate postoperative information shall be charted in the record:
   - The patient’s vital signs and level of consciousness
   - Any medications, including intravenous fluids and any administered blood, blood products and blood components
   - Any unanticipated events or complications (including blood transfusion reactions) and the

management of those events.

- Documentation that the patient was discharged from the post-anesthesia care unit either by the licensed independent practitioner responsible for his or her care or according to approved discharge criteria.
- Documentation of the discharge criteria that determined the patient's readiness for discharge from the PACU.
- The name of the licensed independent practitioner responsible for discharge from the PACU.

E. DISCHARGE SUMMARY

1. A discharge summary shall be written or dictated for patients admitted to the hospital.

2. In the event a patient is seen for minor problems or interventions and is hospitalized less than 48 hours, a final progress note may be substituted for the discharge summary.

3. The discharge summary shall include the following:
   - the reason for hospitalization;
   - a summary of the care, treatment, and services provided;
   - a summary of all consultations;
   - procedures performed;
   - the patient's condition and disposition at discharge;
   - final diagnosis
   - any complications
   - Information provided to the patient and family
   - Provisions for follow-up care

4. In the event of patient death, a summation statement shall be added to the record either as final progress note or as a narrative summary, indicating:
   - the reason for admission;
   - the findings and course in the hospital;
   - events leading to death; and
   - cause of death, if known.

F. EMERGENCY DEPARTMENT

1. Emergency Department records must contain clinical information related to evaluation, treatment, and disposition of the patient. It shall also include the time of the patient's arrival, the means of arrival and by whom transported, any available details of the emergency care rendered to the patient prior to arrival at the hospital, whether (and, if relevant, when and for what) the patient visited the emergency room previously, acknowledgment of any ordered test results, the condition on discharge, and any instructions given to the patient on discharge.

2. The emergency medical record shall be part of the patient's hospital medical record.

3. Each emergency medical record shall be signed by the attending emergency room physician.

G. Authentication of Medical Records

1. All medical record entries shall be dated, timed, and authenticated promptly by the individual who is responsible for ordering, providing, or evaluating the service provided.

2. Electronic Signatures shall be date/time stamped.

3. Signature stamps shall not be accepted under any circumstances. Printed name stamps for legibility may be used in conjunction with the provider's actual signature.

4. Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has the responsibility for the order or the information bearing his authentication.

H. Electronic Signature

1. A practitioner desiring to use electronic signature for authentication must attest in writing that:
   - He / She has a PIN number;
   - Is the only individual who uses the PIN number; and
   - He / She shall not delegate the use of the computerized signature to another.

2. Such attestation shall be maintained in the practitioner's credentialing file in the medical staff office.

3. A copy of the request shall be filed in the practitioner signature file in the Health Information Department.

4. Before applying an electronic signature, the entry must be reviewed for completeness and accuracy, correcting or modifying it as needed.

5. Correction of errors, or the entry of additional information after an entry has been signed electronically must be done by means of an addendum to the original entry.

6. The addendum must also be signed and may be signed electronically.
   In no circumstances shall a single electronic signature authenticate all entries in the medical record.

I. Facsimile Signatures

1. A practitioner's signature transmitted via electronic facsimile is acceptable and does not require additional authentication. A stamped signature shall not be accepted.

2. If the documents faxed are for delinquent medical records, the records shall remain delinquent until the authenticated documents are returned.

J. Delinquent Medical Records

1. All patient records must be completed within thirty (30) days of patient discharge.

2. Notices of deficiencies shall be sent to the practitioner's office for three successive weeks with the first being sent seven days after discharge.

3. The records shall be considered delinquent seven days after the last notice of deficiency or 30 days after discharge whichever is sooner.

4. If medical records of a practitioner are delinquent, the practitioner's clinical privileges may be suspended until the deficiency is corrected. The practitioner shall not be entitled to a hearing if suspended for deficient medical records.

5. Should illness or absence prevent a practitioner from completing his/her records consistent stated timelines the practitioner should notify the HIM Department. An extension may be granted not to exceed the length of the illness or absence.

6. If on suspension because of delinquent records the practitioner shall not be permitted to schedule new admissions and/or surgery, but shall be allowed to provide continued care to current inpatients and patients already scheduled for non-elective surgery or to provide care in the case of an emergency.

K. Medical Records Access

1. The medical record is the property of the Hospital.

2. Subject to applicable laws, access to medical records for all patients shall be afforded to practitioners for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients.

3. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering the periods during which they attended such patients in the hospital.

4. In case of readmission of a patient, previous records shall be available for use by the attending practitioner whether the patient is attended by the same practitioner or by another.

L. Confidentiality and Security of Records

1. The confidentiality of medical records shall be maintained as required by state and federal law.

2. Written consent of the patient is required to release medical information to persons not otherwise authorized to receive this information in accordance with federal and state statutes and regulations regarding the release of information.

3. Original records may be removed from the hospital's custody and control only in accordance with a court order, subpoena, or statute.

4. Unauthorized removal of records from the hospital is considered disruptive behavior and may be grounds for suspension of the practitioner for a period of time to be determined by the Medical Executive Committee. The practitioner shall not be entitled to a hearing if suspended for unauthorized removal of records.

M. Abbreviations, Acronyms, and Symbols

1. Only approved abbreviations, acronyms, and symbols shall be used in documenting in the medical record. HIM shall maintain the approved list.

N. Orders

1. All patient orders shall be documented in the medical record.

2. Practitioner orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly. The use of "renew," "repeat," "resume", or "continue" orders is not acceptable. Orders must be specific.

3. All orders shall be authenticated in the medical record by the ordering practitioner.

4. Verbal and telephone orders are allowed but must be signed by the responsible practitioner within 48 hours after given.

5. Unspecified range or variable orders are discouraged. Range orders received shall be managed by pharmacy according to approved policies and procedures.

6. For each medication, the administration times or the interval between doses must be clearly stated in the order.

7. The use of "prn" or "on call" in a medication order must be qualified with specific indications for administration.

8. All preprinted, standing delegated routine orders (particularly those involving medications) shall be initially evaluated, and, if approved, shall be evaluated periodically thereafter by the Departmental / Pharmacy and Therapeutic Committee and / or the Medical Executive Committee

IV. ANESTHESIA

1. General Anesthesia or Moderate Sedation shall be administered only by -
   - A qualified anesthesiologist
   - A doctor of medicine or osteopathy (other than an anesthesiologist) privileged to administer anesthesia.

- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law and privileged to do so at the Hospital
- A certified registered nurse anesthetist (CRNA), who is under the supervision of the operating practitioner or of an anesthesiologist, who is immediately available if needed.

2. The patient's physical status should be categorized using the ASA classification of the American Society of Anesthesiologists. Surgical patients receiving anesthesia shall be of ASA Physical Status levels of 1 through 4 as defined by the American Society of Anesthesiologists.

3. A pre-anesthesia evaluation of the patient by anesthesia provided must be documented in the medical record in all cases when General anesthesia shall be provided prior to the patient's transfer to the operating or procedure area and before preoperative medication has been administered. If time does not permit such documentation prior to a non-elective surgery case, such documentation shall be made as soon as possible thereafter.

4. When General anesthesia is given an intra-operative anesthesia record shall be created for each patient. The anesthesia provider shall record in the medical record:
   - evidence of pre-anesthesia check of anesthesia equipment;
   - monitoring equipment utilized;
   - patient's physiological monitored vital signs;
   - level of consciousness;
   - all anesthesia drugs and agents used as well as all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents; and other drugs, intravenous fluids, and blood and blood components.

5. Patient discharge from the post-anesthesia recovery unit must be based on a physician decision evidenced by:
   - a written physician order;
   - a recorded verbal physician order; or
   - according to approved discharge criteria.

6. At least one post-anesthesia visit must be made by an anesthesiologist after an inpatient has left the PACU. This visit shall be documented in the medical record and should describe the presence or absence of anesthesia-related complications.

7. Post-anesthesia assessment must include:

   a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
   b. Cardiovascular function, including pulse rate and blood pressure;
   c. Mental status;
   d. Temperature;
   e. Pain;
   f. Nausea and Vomiting;
   g. Post-Operative Hydration

8. General anesthesia shall be administered only by an Anesthesiologist or CRNA. In the case of a CRNA, the "surgeon of record" and the "supervisor of the CRNA" may not be one in the same when general anesthesia, requiring intubation, is given.

9. "Moderate sedation" may only be administered by a physician or CRNA who have demonstrated competence as determined by the Credentials Committee upon appointment and/or reappointment.

10. All patients receiving general, spinal or other major regional anesthesia shall go to the post anesthesia care unit. Patients receiving only local anesthesia may go to the post anesthesia care unit at the request of the responsible surgeon.

11. The responsible anesthesiologist or CRNA shall be in constant attendance during the entire procedure. Following the procedure, the anesthesiologist or qualified designee shall remain with the patient upon transport to the post-anesthesia care unit and as long thereafter as required by the patient's condition relative to anesthesia status, and until responsibility for proper patient care has been assumed by another qualified individual.

V. DRUGS AND MEDICATIONS

1. All drugs and medications administered to patients shall have been approved by the Food and Drug Administration. The only exceptions are those drugs administered under an approved protocol for investigational or experimental drug use which has been approved by an Institutional Review Board/Committee that is acceptable to the Medical Executive Committee, and has been approved by the Board of Managers. When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically not defined as a drug or medication, administration of these substances shall also be in accordance with an established protocol that has been approved by the pharmacy. Proprietary remedies should be avoided, and if an attending practitioner orders one for a patient, the pharmacy shall obtain consult with the prescribing physician to determine the medication therapy regimen.

2. Investigational or experimental drugs shall be used only under the direct supervision of the principal investigator who shall be a physician member of the medical staff and who is responsible for securing the necessary consents. The investigator shall provide to the Hospital President or Board of Managers evidence of adequate liability insurance covering the use of investigational or experimental drugs.

3. The protocol for use of an investigational or experimental drug shall be submitted to the Institutional Review Board/Committee which shall then make its recommendation to the MEC the MEC shall then make its recommendation to the Board of Managers which has the final authority to approve.

4. When nurses are required to administer an investigational drug, the principle investigator shall ensure they shall be provided access to basic information concerning the drug, including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known.

5. When a patient is admitted while on an investigational drug from outside of the hospital, the medication may be continued as follows:
   - A copy of the patient's informed consent must be approved.
   - A copy of the protocol must be submitted to the Pharmacy.
   - The medication must be controlled by the Pharmacy.
   - The medication shall be delivered to the Pharmacy and not left with patient or on the Nursing unit.
   - All unused drugs must be returned to the investigator / patient.

   The attending physician must be a member of Hospital medical staff but the principal investigator need not be a member of the medical staff. The attending physician must provide the pharmacy a photocopy of the patient's informed consent, which shall be placed in the chart, and a copy of the protocol to file in the Pharmacy.

6. The pharmacy shall store any investigational drugs used in the hospital and be responsible for labeling and dispensing in accordance with the investigational protocol provided.

7. If allowed by their physician, patients may bring their own medications for use in the hospital, but may not self-administer those medications.

8. Drugs brought into the hospital by patients may only be administered by the nursing staff after the drugs have been identified by the hospital pharmacist, the pharmacy technician, or the patient's nurse; there is a written order from the responsible practitioner to administer the drugs, the medication is labeled, and the drug is not outdated.

9. Unless otherwise ordered, the Pharmacy shall have the authority to select the brand within generically equivalent products. The product shall be selected according to efficacy, toxicity, pharmacokinetic properties, cost and approved and certified by the FDA as being bioequivalent to brand-name products.

10. Therapeutic interchange: Medication classes can be reviewed to select the specific medications with similar efficacy to be used by the hospital for its patient population. When approved by the Medical Staff, these medications can be automatically substituted for the specific drug prescribed, unless the practitioner specifies by order "Do Not Substitute".

11. When, in the opinion of the nursing staff or the pharmacist, a drug dosage ordered represents a potential hazard (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition) to the patient, and the prescribing practitioner disagrees, the chairman of the department/service to which the practitioner is assigned or the Chief of Staff shall be consulted, and if he also agrees that the administration of the drug as ordered is potentially hazardous, the attending practitioner may be required to administer the drug personally and submit a written prescription to the pharmacy separate from that of the order sheet.

12 The Medical Executive Committee may restrict the use of a specific drug or class of drugs, either entirely or for use only in stated conditions or for use only on the consent of the Medical Executive Committee.

VI. CONSULTATIONS

1. The attending practitioner is responsible for requesting consultation when indicated and for securing a qualified consultant. The attending practitioner shall document the requested consultation in the medical records.

2. The requesting practitioner shall make reasonable effort to communicate directly with the consultant prior to the consultation.

3. Any qualified practitioner with clinical privileges in this hospital may be called by the practitioner responsible for the patient to provide consultation within the consultant's area of expertise.

4. When the required consultative expertise is not available through the existing medical staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by seeking temporary privileges for a qualified practitioner in accordance with the Medical Staff Bylaws.

5. Consults should be obtained when specific areas of expertise are needed to attend to the care of a patient.

VII. GENERAL REQUIREMENTS

1. All Internal Medicine and Family Practice members of the medical staff shall be available on a rotational schedule to provide medical care or consultation to any patient in the Hospital who is found by the Attending physician on duty to require such care. These duties may be extended to any or all members of medical staff as a whole when additional physician coverage is needed to meet the hospital's emergency care mission and obligations.

2. Specialty on-call coverage shall be available twenty-four (24) hours a day, seven (7) days a week. Schedules, names, and contact numbers for on-call practitioners shall be available at all times in the hospital. All specialties with four or more practitioners on active staff shall be listed on the on-call rotation. Practitioners 60 years or older shall not be required to take specialty on-call. In the event an on-call practitioner cannot be contacted, the next listed on-call practitioner shall be called.

3. A determination as to whether the on-call practitioner must physically assess the patient in the Hospital is the decision of the attending practitioner. The on-call practitioner shall come to the Hospital if requested by the Attending practitioner. If unavailable for any reason, he or she shall secure a satisfactory alternate from the medical staff to take call.

4. Written consent of the patient is required for release of medical information to individuals not otherwise authorized to receive this information.

5. In addition to a general consent obtained by the hospital at the time of the patient's admission, specific informed consent must be obtained as required by law. The attending and/or treating

practitioner is responsible for obtaining informed consent and documenting same in the medical record. All regulatory requirements relating to informed consent shall be followed. Both the patient (or authorized patient representative) and responsible practitioner must sign the informed consent form prior to the procedure.

6. In the event of a patient death in the hospital, the deceased shall be pronounced dead by a physician. The body shall not be released until a death note is completed and placed in the medical record of the deceased.

7. All medical staff members shall report questionable deaths and recommended meaningful autopsies whenever possible.

A. A medical staff member is required to report a death to the medical examiner in the following circumstances:

1) Cases in which the deceased is dead on arrival (DOA).

2) Cases in which an individual expires within 24 hours following admission to the emergency room or ward.

3) When death is, or is suspected to be, from accidental, suicidal or homicidal causes, no matter how long the person has been hospitalized or has survived the injuries. The time span may run for minutes to years.

4) Cases of anesthetic deaths, including those under the initial induction and those who do not recover following anesthesia.

5) Deaths that occur during or immediately following any diagnostic or therapeutic procedure in the hospital.

6) Any death where the disease process responsible is either work-related or suspicious of being aggravated or accelerated at work.

7) Stillbirths and neonatal deaths when maternal injury has occurred or is suspected either prior to admission or during delivery.

8) Maternal deaths, whether during or following delivery and including any death where abortion is suspected.

9) The death of a person in custody or under confinement.

10) Any death of a known or suspected IV drug user.

11) Any death of a child younger than six (6) years old.

B. Medical Staff members may not require an autopsy, but an autopsy may be of benefit and should be considered in the following circumstances:

1) Deaths in which autopsy may help to explain unknown or unanticipated complications.

2) Deaths in which the cause of death is not known with certainty on clinical grounds.

3) Unexpected deaths during medical or surgical diagnostic procedure or therapy.

4) Unexpected outpatient or emergency death

5) Family request.

8. All practitioners shall participate in patient discharge planning in accordance with the Hospital utilization review plan or other written requirements.

9. All practitioners shall comply with requirements of the Hospital's Incident / Occurrence Screening / Risk Management Program.

10. All practitioners are responsible for participating in case of a declared disaster and cooperate with the disaster plan. They shall participate in disaster drills as necessary.

11. The ordering of any baseline admission testing (e.g., laboratory, X-ray, electro cardio-gram, etc.) shall be the responsibility of the attending practitioner on an individual patient basis.

12. Clinical laboratory tests shall be done at the Hospital or at an outside (reference) laboratory recommended by the director of the pathology and medical laboratory services and approved by the medical staff. Practitioners who have such tests / examinations performed by laboratory sources other than these must enter the results in the history or progress note section of the medical record.

13. The radiology department / service shall provide authenticated reports for all radiologic examinations performed in the hospital and, when requested, for review of examinations performed outside the hospital. The attending practitioner may record his own interpretation in the history or progress note section of the medical record. When special diagnostic procedures can be properly interpreted only with the findings and observations of the authorized practitioner (e.g., cardiologist) performing the procedure, this practitioner shall be responsible for rendering the official report for the medical record.

14. Practitioners requesting diagnostic examinations by the pathologist or radiologist shall include in the written request all relevant information available to assist in the determination of a diagnosis/impression and proper use of resources.

15. Blood that has been cross matched shall be held for 48 hours at which time it shall be released from hold unless reordered. Prior to release, the ordering practitioner shall be notified. For cases in which cross matched blood is frequently ordered but not used, the use of type and screen system may be considered instead of cross matching.

16. Oxygen and respiratory therapy shall be administered in accordance with the responsible practitioner's orders. In cases where the duration of treatment is not specified or is stated

indefinitely, the nurse shall notify the responsible practitioner and confirm whether the treatment should be continued or discontinued.

17. Radiographs and pathology slides are the property of the hospital and may be lent to other hospitals, practitioners, or research institutions for appropriate reasons and only with the written permission of the patient in accordance with the policies, rules and regulations of the radiology and pathology department, and all applicable state and federal laws, rules, statutes and regulations.

18. Services provided shall be provided by all members of the medical staff in a non-discriminatory manner without regard to age, sex, race, color, national origin, handicapping condition, or disability.

19. Each member of the medical staff shall specify a member of the medical staff with appropriate privileges who shall be available to attend his patients in an emergency. In case of failure to name such a practitioner, the Chief of Staff, his/her designee or the Hospital President (in order of availability) shall have authority to call any qualified member of the medical staff if necessary.

20. In the event of a positive TST or BCG variance a TB Questionnaire must be completed. In the event that practitioner should develop symptoms, all necessary hospital departments shall be notified.

VIII. EMERGENCY SERVICES

1. The disposition of each patient shall be a physician responsibility.

2. The emergency room shall not be used for routine outpatient visits.

3. The established list of procedures permitted to be performed in the emergency room shall not be exceeded except in a bona fide emergency.

4. Procedures requiring general or major regional anesthesia shall not be performed in the emergency room, but must be performed in the surgical suite.

5. In an emergency case in which it appears that a patient requires admission to a hospital, the practitioner shall make the appropriate transfer arrangements.

6. The emergency room physician shall render his interpretation of X-rays in writing, it shall be placed in the chart and a copy of this report shall be made available to the radiologist. In cases in which the radiologist's interpretation of an X ray differs from that initially made by the emergency physician, the radiologist shall see to it that a copy of the radiologist's report is made available and brought to the attention of the emergency physician and the patient or the patient's private practitioner, and shall see to it that the patient is informed of the final reading.

7. When a transportable patient who is in the emergency room requires medical staff consultation/treatment not available, the patient shall be transferred to an appropriate facility as soon as possible, subject to compliance with the hospital's transfer protocol, regulatory requirements, and subject to having first obtained acceptance by that facility through a physician or other qualified health care provider.

IX. SURGICAL CARE

1. The responsible practitioner shall record and authenticate a preoperative diagnosis prior to surgery.

2. All pre-operative test reports/results (laboratory, X-ray, ECG, etc.) shall be recorded in the medical record prior to the performance of any elective surgical procedure.

3. Specimens removed at surgery shall be sent to the hospital pathologist for evaluation except for authorized exempt specimens (see attachment A).

4. Ambulatory same-day surgical procedures are limited to only those surgical procedures approved by the Board of Managers upon recommendation of the MEC.

5. Ambulatory same-day surgery shall be included in surgical case evaluations performed by the department of surgery and / or medical executive committee.

6. Practitioners performing surgical procedures shall report any post discharge infections to the hospital's infection control officer.

7. Surgeons must be in the operating room and ready to begin surgery at the time scheduled. In the event that the surgeon is not available at the scheduled time, one (1) courtesy phone call shall be made to the surgeon after 15 minutes. After a second fifteen (15) minutes expires, the case shall be bumped and rescheduled. Only upon approval of the OR director shall the operating room be held longer than 30 minutes, after the time the case was scheduled.

8. Surgery may be scheduled from 7:30 a.m. to 4:00 p.m. on weekdays exclusive of holidays recognized by the hospital. Cases should be scheduled to complete by 6:00 p.m. Scheduling is done through centralized scheduling office. After hours, holidays, and weekends, scheduling is done through the nursing house supervisor.

9. Surgical site verification is performed prior to the surgical procedure according to approved policy and procedure.

10. Prior to the start of any surgical or invasive procedure, the surgeon and surgical team shall conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active communication techniques.

11. Physicians and other practitioners shall abide by the OR/hospital rule on use of appropriate attire to include surgical clothes, surgical mask, surgical cap and shoe covers. Surgical mask are to be worn over the nose and mouth and changed at least between each case.

12. Practitioners called to consult in the operating suite shall comply with the OR/hospital dress code.

13. If at the end of a surgical procedure, the sponge, sharps, or instrument count is incorrect, the patient must be X-rayed and the film read prior to moving the patient out of the surgical suite, unless the patient's condition dictates otherwise.

14. The primary surgeon must remain available to provide continuous care to each of his hospitalized patients. Availability is defined by response time, individual patient conditions, and prudent medical judgment reflecting current acceptable standards of care; but in no case shall exceed thirty (30) minutes response time. Should a surgeon not be able to provide such care, he shall arrange for and specify in the Physician's Orders of the medical record, a member of the medical staff with appropriate privileges who shall be able to attend to his patient. In case of failure to name such a practitioner the chief of the medical staff or the hospital president shall have the authority to call any qualified member of the medical staff as necessary.

X. INFECTION CONTROL

1. Reporting of infections
   - The attending practitioner shall notify the Infection Prevention Nurse if a patient has an infection which is transmissible within the hospital.
   - If isolation is required and the attending practitioner is not available, nursing may isolate the patient until the practitioner can be contacted.
   - The attending physician shall notify the Infection Prevention Nurse of patient infections discovered after discharge which may have originated in the Hospital.

2. Isolation
   - In the event of a question about the appropriateness of isolation procedures, discussion shall take place between the involved member and the Infection Prevention Nurse.
   - If a question about isolation procedures cannot be resolved by the involved member and the Infection Prevention Nurse, the Infection Prevention Nurse has the authority to implement appropriate measures until the matter is presented to the Infection Control Committee.

XI. SELF TREATMENT OR TREATMENT OF FAMILY MEMBERS

Practitioners should not treat themselves or members of their immediate family Professional objectivity may be compromised when a family member or the Practitioner is the patient; the Practitioner's personal feelings may unduly influence his or her professional judgment, thereby interfering with the care being delivered. Practitioners may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the Practitioner is a family member. When treating themselves or family members, Practitioners may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the Practitioner.

Concerns regarding patient autonomy and informed consent are also relevant when Practitioners attempt to treat members of their family. Family members may be reluctant to state their preference for another

Practitioner or decline a recommendation for fear of offending the Practitioner. Likewise, Practitioners may feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of a family member. In emergency settings or isolated settings where there is no other qualified Practitioner available. Practitioners should not hesitate to treat themselves or family members until another Practitioner becomes available. In addition, while Practitioners should not serve as primary or regular care providers for family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for Practitioners to write prescriptions for controlled substances for themselves or family members. They shall not participate in the care of a family member as an admitting physician or consultant.

XII. DISASTER PLAN

All members of the Medical Staff, regardless of category, shall participate in the Hospital Disaster Plan including all disaster readiness drills and assignments in the event of a disaster.

XIII. RESTRAINTS

A. General Rules

1. Restraints (manual or chemical) or seclusion may only be imposed for the immediate physical safety of the patient, a staff member or other.

2. Restraints must be discontinued at the earliest possible time.

3. Use of Restraints for the following reasons is prohibited:

    a. Coercion, discipline, convenience or retaliation.

    b. When based solely on the patient's history of dangerous behavior.

    c. As a routine method for preservation of falls.

B. Orders for Restraints

1. General

    a. Except in emergency situations there must be an order for the restraints prior to application.

    b. In emergency situations an order must be given either during the emergency application of restraints or seclusion or immediately thereafter.

c. The order must come from the physician or licensed independent practitioner responsible for the care of the patient. If not, the attending physician must be consulted as soon as possible. If the attending physician is unavailable patient responsibility must be delegated to another physician.

d. PRN or standing orders are prohibited from restraints or seclusion.

e. Restraints or seclusion may not be stopped and restarted under the same order.

f. Trial release of restraints or seclusion may not be under the same order.

g. Each order for restraint or seclusion must contain the following information:

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

2. Orders for violent or self-destructive behavior

a. In any 24 hour time period orders for restraints are limited to the following time periods;

i. Up to four hours for age 18 and older.

ii. Up to two hours for patients age 9 to 17.

iii. Up to one hour for patients under the age of 9.

b. When an order is about to expire, a physician may not renew the order without at least a reported RN assessment.

c. If a patient remains in restraints or seclusion 24 hours after the original order, the attending physician must conduct a face-to-face re-evaluation before a new order for continued use may be written, and the finding of the evaluation must be documented.

3. Order for restraints for safety/non-violent/non-self-destructive behavior.

a. Such orders are considered in full force and effect for 24 hours.

b. After 24 hours a new order is necessary for restraints to continue.

C. Training

Physicians authorized to order restraints or seclusions must have a working knowledge of these rules and regulations related to restraints as well as the restraint policy of Texas Health Harris Methodist Hospital Southlake. The working knowledge must include but is not limited to the following:

- A patient's right regarding the use of restraints or seclusion
- Prohibitions on such use
- Ordering requirements
- Requirements in timeframes for patient assessment.

APPROVALS:

These Rules and Regulations are adopted by the Medical Staff

Michael Pettibon, MD President of Medical Staff	**July 11, 2007** Date
O. David Taunton, MD Chief of Staff	**June 10, 2009** Date
O. David Taunton, MD Chief of Staff	**February 8, 2012** Date
O. David Taunton, MD Chief of Staff	**February 13, 2013** Date
O. David Taunton, MD Chief of Staff	**February 12, 2014** Date
O. David Taunton, MD Chief of Staff	**February 10, 2015** Date

These Rules and Regulations are approved by the Governing Body

Mary Brian, MD Chairman of the Governing Body	**July 18, 2007** Date
David Rothbart, MD Chairman of the Governing Body	**July 1, 2009** Date
David Rothbart, MD Chairman of the Governing Body	**February 15, 2012** Date
David Rothbart, MD Chairman of the Governing Body	**February 20, 2013** Date
David Rothbart, MD Chairman of the Governing Body	**February 19, 2014** Date
David Rothbart, MD Chairman of the Governing Body	**February 18, 2015** Date

ATTACHMENT A

AUTHORIZED EXEMPT SPECIMEN LIST

All tissue is sent to Pathology except what is outlined as exempt. The following surgical specimens are not required to be sent for pathological review:

1. Orthopedic Appliances
2. Foreign Bodies
3. Amputations of Traumatically Injured Members
4. Foreskin
5. Normal Placentas
6. Teeth, Provided the Anatomic Name or Anatomic Number of Each Tooth or Fragment of Each Tooth, is Recorded in the Medical Record.
7. Toenails / fingernails
8. Portion of Rib Removed to Enhance Operative Area
9. Cataracts
10. Portion of the Iris Removed During Iridectomy
11. Normal Cartilage (Turbinates are not exempt), Bone, or Skin Removed during Any Open Reduction / Wiring of Facial Fractures, or Creation of Nasal Antral Window.
12. Port-a- Caths
13. Bone segments removed as part of corrective or reconstructive orthopedic procedures (e.g., rotator cuff repair, synostosis repair, spinal fusion).
14. Middle ear ossicles
15. Unused tissues harvested from autologous grafts (bone, tendon, nerve)
16. Liposuction products
17. Shaving from arthroscopic debridement related to traumatic injury
18. Scars of prior operation, except when the scar resulted from a surgical procedure involved the removal of a benign or malignant tumor (such scars must be submitted)
19. Skin tags, but only if they are less than 3 millimeters or greater dimension
20. Artifacts
21. Implanted stimulators
22. Therapeutic radiation sources
23. Prosthesis
24. Normal tissue resulting from cosmetic surgery
25. Intervertebral disc tissue
26. organs and tissue to be transplanted
27. blood

ADDITIONS TO MEDICAL STAFF
RULES AND REGS

II. ADMISSION AND DISCHARGE

Explanation:

MEC ACTION:

Approved and Recommended: February 10, 2015

Chief of Staff: David Taunton, MD

BOM ACTION

Approved: February 18, 2015

Chair of Board of Managers: David Rothbart, MD

DELETIONS TO MEDICAL STAFF
RULES AND REGS

II. ADMISSION AND DISCHARGE

MEC ACTION:

Approved and Recommended: February 13, 2018

Chief of Staff: David Taunton, MD

BOM ACTION

Approved: February 21, 2018

Chair of Board of Managers: David Rothbart, MD