MEDICAL STAFF
RULES AND REGULATIONS
OF
BAYLOR SCOTT & WHITE MEDICAL CENTER - HILLCREST

Approved by MS Executive Committee: 4/9/15
Approved by Board of Directors: 5/1/15

***Amendment to Article I, Section 10*:**

Approved by MS Executive Committee: 8/13/20
Approved by Board of Directors: 8/19/20

Amendment to Article III, Section 7(c) (2)and (3);
Amendment to Article III, Section 12, 13 and 14;
Amendment to Article V, VI, VII, VIII and IX:

Approved by MS Executive Committee: 12/10/20
Approved by Board of Directors: 12/16/20

Horty, Springer & Mattern, P.C.

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ARTICLE I

ADMISSION

Section 1. Who May Admit Patients:

(a) The Medical Center shall accept patients for care and treatment commensurate with its clinical services offered and the availability of Medical Center beds. A patient may be admitted to the Medical Center only by physicians, dentists and podiatrists who have been appointed to the Medical Staff.

(b) Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been entered in the patient's Medical Record. All Medical Staff members shall be governed by the official admitting policies of the Medical Center. In emergency cases, the provisional diagnosis shall be entered as soon after admission as possible.

Section 2. Admitting Medical Staff Member's Responsibilities:

(a) Each patient shall be the responsibility of the admitting Medical Staff member. The admitting Medical Staff member shall be responsible for the medical care and treatment of the patient while in the Medical Center, including the prompt and accurate completion of the Medical Record, necessary patient instructions, and transmitting reports of the condition of the patient to the referring practitioner and to the patient and other appropriate parties.

(b) The admitting Medical Staff member (or designated office employee) shall notify the admitting office (or Nursing Supervisor if admitting office is closed) of each admission and shall provide all required information regarding the admission prior to sending the patient to the Medical Center.

(c) Whenever the admitting Medical Staff member's responsibilities are transferred to another Medical Staff member, other than routine call coverage, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's Medical Record, whereupon the member to whom the patient has been transferred shall acknowledge the transfer by entering an acceptance note on the Medical Record and shall be responsible for the care of that patient until the

patient is discharged from the Medical Center. The admitting practitioner shall be responsible for verifying the Medical Staff member's acceptance of the transfer.

(d) The admitting Medical Staff member shall provide the Medical Center with any information concerning the patient that is necessary to protect the patient, other patients or Medical Center personnel from infection, disease or other harm, and to protect the patient from self-harm.

Section 3. Care of Unassigned Patients:

In the case where a patient who is evaluated by the emergency department requires Medical Center admission and does not have an attending physician with clinical privileges at the Medical Center, or has not requested that a specific member of the Medical Staff with the appropriate clinical privileges assume his or her care, the patient shall be assigned to the appropriate on-call Medical Staff member.

Section 4. Dental and Podiatric Patients:

(a) A patient admitted for dental or podiatric procedures shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending dentist or podiatrist and the admitting Medical Staff member. The attending Medical Staff member must provide the history and physical examination and medical care for the patient. However, dentists shall be responsible for that part of their patients' history and physical examination that relates to dentistry and podiatrists shall be responsible for that part of their patients' history and physical examination that relates to podiatry.

(b) Notwithstanding the requirements of Section 4(a) of this Article, oral and maxillofacial surgeons who admit patients without significant health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee. However, if any significant medical condition is disclosed in the patient's medical history or physical examination, or if any medical problem arises during or following surgery, the oral and maxillofacial surgeon shall promptly obtain appropriate medical consultation.

Section 5. Alternate Coverage:

(a) Each Medical Staff member shall provide professional care for his/her patients in the Medical Center by being available or making arrangements with an alternate Medical Staff member who has appropriate clinical privileges at the Medical Center to care for the patients. Failure to meet the requirements concerning availability may result in loss of clinical privileges.

(b) If an attending physician or that physician's designated call group is going to be unavailable to care for a patient, the attending physician shall make an entry on the order sheet of the patient's Medical Record with the name of the alternate Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability.

Section 6. Transfer of Patients to Another Facility:

(a) Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel. When it is determined, based on the patient's assessed need and the Medical Center's capabilities, that transfer of a patient to another facility is in the patient's best interest or if for any reason the Medical Center cannot admit a particular patient who requires inpatient care, the Medical Center and/or the attending physician shall assist the patient in making arrangements for care at another facility so as not to jeopardize the health and safety of the patient.

(b) If the patient is to be transferred to another medical facility, the transferring physician shall enter all pertinent information on the patient's Medical Record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has agreed to accept the patient. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

Section 7. Priorities for Admission:

(a) Patients shall be admitted on the basis of the following order of priorities:

(1) **Emergency Admission** – includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger.

(2) **Urgent Admission** – includes non-emergency patients whose admission is considered imperative by the attending Medical Staff member. Urgent admissions shall be given priority when beds become available over all other categories except emergency.

(3) **Pre-Operative Admission** – includes patients already scheduled for surgery.

(4) **Routine Admission** – includes all other admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the Medical Center's utilization management plan.

(b) Before admitting a patient, the attending Medical Staff member or a designee shall contact the admitting office to ascertain whether there is an available bed. If there is any question concerning the admission of a patient, the Chief Medical Officer, or designee, with appropriate Medical Staff consultation, shall determine the necessity for or deferment of the admission.

(c) When possible, the patient will be admitted to the appropriate floor or nursing station which the Medical Center has customarily designated as providing care in a specific field for a specific service, such as medical, surgical, obstetrics, gynecology, pediatrics, and intensive care units. When deviations are made from the customary assigned areas, the Nursing Supervisor will attempt to correct these assignments at the earliest possible time in keeping with transfer priorities.

(d) The Executive Committee may define categories of medical conditions and criteria to be used in establishing priorities with regard to patient admissions and the proper review thereof by an appropriate committee or member of the Medical

Staff. These shall be developed by the clinical departments where necessary and approved by the Executive Committee.

Section 8. Priorities for Patient Transfer Within the Medical Center:

Patients shall be transferred within the Medical Center on the basis of the following order of priorities:

(a) from the Emergency Department to the appropriate patient bed;

(b) from the obstetrical patient care unit to the general care area, when medically indicated;

(c) from an intensive care unit to the general care area;

(d) from temporary placement in an inappropriate geographic or nonclinical service area to the appropriate clinical service area for that patient; and

(e) transfer from semiprivate to private or from private to semiprivate room upon the request of the practitioner or patient, with mutual agreement of both the patient and practitioner, when such transfer is feasible from the standpoint of availability of the appropriate bed.

A patient shall not be transferred without the prior approval of the responsible physician, dentist, or podiatrist. In urgent or extreme circumstances, the Chief Medical Officer, or designee, with appropriate Medical Staff consultation, may approve the transfer decision.

Section 9. Emergency Services and Emergency Admissions:

(a) Twenty-four hour emergency service physician coverage is provided according to the policies set forth by the Medical Staff Executive Committee and the administration of the Medical Center.

(b) An appropriate record of care shall be kept for every patient receiving emergency service and shall be incorporated in the patient's Medical Record, if present. Such record shall contain information concerning the time of the patient's arrival, means of arrival and by whom transported, and the conclusions at the termination of treatment, including final disposition, condition, instructions for follow-up and whether the patient left the Medical Center against medical advice. The Medical

Record must also include a notation that a copy of the record is available to the practitioner or medical organization providing follow-up care.

(c) Each patient's Medical Record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

(d) Medical Staff members admitting emergency cases shall be prepared to justify to the Executive Committee and to the Chief Executive Officer, or designee, that the emergency admission was a bona fide emergency. Documentation of the emergency nature of each admission shall be provided by the history and physical examination recorded in the patient's Medical Record as soon as possible after admission. In the case of a psychiatric admission, the initial workup shall also include a mental status examination and proposed treatment plan.

(e) Emergency admission patients who do not have a personal physician with admitting privileges shall be assigned to a Medical Staff member with privileges in the specialty to which the diagnosis indicates an assignment is appropriate. Where the type of specialist required is not clear, the Emergency Department physician, the President of the Medical Staff or the Chief Medical Officer, or designee, shall assign the patient to a Medical Staff member who has been granted appropriate clinical privileges. Any disputes will be handled with consultation by the appropriate department chairman. An Emergency Department call roster shall be published annually for each clinical section, department, or field of medical care which is required to serve patients in the Emergency Department. It shall be posted in the nursing station of the Emergency Department and shall be available in the Medical Staff Office, Nursing Service Office, and Chief Executive Officer's or designee's office. Copies of this roster shall be sent to all members of the active and associate staff taking call, and may be sent to every member of the Medical Staff. Rotation in the various specialties may be determined by each section as being daily, weekly, bi-weekly, monthly, etc., so long as it is kept uniform and is appropriately posted. In the event a member is subject to call but is unable to respond to an emergency call, he/she shall provide substitute coverage and shall notify the Emergency Department of the member or members who will provide such substitute coverage.

(f) Failure of the assigned member to respond to an emergency call may result in a professional review action, unless that member presents, in writing, to the President of the Medical Staff and the Chief Executive Officer, or designee, an acceptable reason for not attending the patient. An unexcused failure to respond to an emergency call or to comply with Medical Center policy concerning emergency call shall be reported immediately to the Medical Staff Quality Improvement Committee.

Section 10. Emergency Department and/or Obstetrical Unit: Medical Screening

Medical Screening Examinations may be performed by a Qualified Medical Person defined as:

(a) A licensed physician with clinical privileges granted by the governing board; or

(b) A post graduate training physician as defined by the Accreditation Council for Graduate Medical Education or additional accrediting body supervised by a licensed physician with clinical privileges granted by the governing board; or

(c) A licensed nurse practitioner, nurse mid-wife, clinical nurse specialist, or physician assistant with advanced training, certification and clinical privileges granted by the governing board; or

(d) A Registered Nurse who has completed appropriate education, training and competency assessment through hospital and emergency room and/or labor and delivery unit specific orientation, for the sole purpose of conducting or participating in the patient assessment, reaching a nursing diagnosis (if indicated), and reporting the nurse's assessment, all as part of the medical screening examination. Such assessment will be done pursuant to the appropriate policies, protocols, and/or medical orders.

Section 11. Utilization Management:

(a) The attending Medical Staff member or appropriate consultant shall be required to routinely document the need for continued hospitalization after specific periods of stay, as may be outlined by governmental regulations or third-party providers and as identified by the Medical Staff Quality Improvement Committee.

(b) The Medical Staff Quality Improvement Committee, in accordance with the Utilization Management Plan, will review inpatient cases of questionable medical necessity for admission to the Medical Center or for extended hospitalization care. Trends or concerns of an individual Medical Staff member's utilization of hospital services as identified by the Medical Staff Quality Improvement Committee will be forwarded to the Credentials Committee.

ARTICLE II
MEDICAL ORDERS

Section 1. General Requirements:

(a) Whenever possible, orders will be entered directly into the Medical Record by the ordering practitioner utilizing the Computerized Physician Order Entry ("CPOE"). Written or paper-based orders should be documented on appropriate forms as approved by the Medical Center. Any such written or paper-based orders will be scanned and entered into the patient's Medical Record via the CPOE in accordance with Medical Center policy. Orders must be documented clearly, legibly, and completely. Orders which are illegible or improperly documented shall not be carried out until they are clarified by the ordering Medical Staff member and are re-documented by the appropriate health care provider.

(b) All previous orders shall be canceled when patients go to surgery. Post-operative orders may include an order to "resume all pre-operative orders" when entered by the surgeon after review of the patient's Medical Record. However, "resume all pre-operative orders" is **not** applicable to medication orders which must be reentered by the physician.

(c) All orders must be completely re-entered when a patient is transferred from one service to another.

(d) When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be re-entered.

(e) No order shall be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

(f) Only those abbreviations, signs, and symbols authorized by the Medical Center shall be used in the Medical Record. However, no abbreviations, signs, or symbols shall be used in recording the patient's final diagnosis or any unusual complications.

(g) Diagnostic tests and procedures, and surgery, therapy, treatment and care performed on or provided for patients while admitted shall be provided through

Medical Center facilities or, if Medical Center facilities are not available, through other facilities for which prior arrangement is made with the Medical Center.

Section 2. Who May Enter Orders:

(a) Medical Staff members and allied health professionals shall have the authority to enter orders only as permitted by their licenses and by the clinical privileges or scope of practice granted them by the Medical Center.

(b) All orders must be entered in the patient's record, dated, timed, and signed.

(c) Entries in physicians' progress notes shall be made only by Medical Staff members, residents, Medical Associates or Medical Assistants.

(d) Residents are permitted to enter orders for treatment at the sole discretion and responsibility of the Medical Staff member responsible for the patient's care. This does not prohibit the patient's attending physician from entering orders without the agreement of the resident.

Section 3. Verbal Orders:

(a) A verbal order (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is impractical for such order to be entered into the patient's Medical Record by the responsible practitioner.

(b) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the Medical Record of the patient. The qualified personnel taking the verbal order shall read it back aloud to the prescribing Medical Staff member in order to verify the verbal order, prior to transcription in the patient's Medical Record.

(c) A verbal order shall include the date, time, and full signature and title of the person to whom the verbal order has been given and shall be authenticated by the ordering physician, or a practitioner who is responsible for the patient's care in the Medical Center, within 48 hours. Repeated violations of this rule shall be reported to the Quality Improvement Committee.

(d) Acceptance of a verbal order is limited to the following, with noted restrictions:

(1) a Medical Staff member with clinical privileges at the Medical Center;

(2) a registered nurse;

(3) a licensed vocational nurse;

(4) a registered pharmacist who may transcribe a verbal order pertaining to drugs;

(5) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(6) a radiology technician who may transcribe a verbal order pertaining to specific contrast medications for use in the radiology department;

(7) a physical therapist who may transcribe a verbal order for specific medications pertaining to treatments in the department of physical therapy;

(8) Medical Associates;

(9) individuals allowed to work under a temporary permit, i.e., graduate nurses, graduate vocational nurses, who are employed by the Medical Center or serving on special duty; student nurses may take orders which are then cosigned by an R.N.;

(10) a registered medical technologist who may transcribe a verbal order for blood or blood products;

(11) a licensed dietitian who may transcribe a verbal order for the patient's dietary needs;

(12) a speech language pathologist who may transcribe a verbal order for speech pathology needs of a patient; and

(13) an occupational therapist who may transcribe a verbal order for occupational needs of the patient.

(e) Acceptance of verbal orders by other departments in the Medical Center shall be determined by the Executive Committee.

Section 4. Orders for Specific Procedures:

(a) All requests for procedures or other diagnostic tests shall contain concise clinical information and include the reason for the examination.

(b) All requests for outpatient procedures or tests shall include appropriate diagnosis codes.

Section 5. Standing Order Protocols:

(a) For all standing orders, order sets and protocols, review and approval of the Executive Committee are required. Where appropriate, input will be sought from nursing and pharmacy. Prior to approval, the Executive Committee will confirm that the standing order, order sets, and protocols are consistent with nationally recognized and evidence-based guidelines. The Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols. All standing orders, order sets and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

(b) If the use of a standing order, order set or protocol has been approved by the Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the Medical Center and acting within his or her scope of practice.

(c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's Medical Record by the ordering practitioner or another practitioner responsible for the care of the patient.

ARTICLE III

MEDICAL RECORDS

Section 1. General Rules:

(a) A Medical Record shall be maintained for each patient who is evaluated or treated as an inpatient, outpatient, or emergency patient or who receives services in the hospital-administered home care program. The attending Medical Staff member shall be responsible for the preparation of a timely, accurate, complete and legible Medical Record for each patient under his/her care. This responsibility cannot be delegated.

(b) The contents of the Medical Record shall be pertinent and current. A single attending physician shall be identified in the Medical Record as being responsible for the patient at any given time.

(c) No abbreviations, signs or symbols shall be used to record a patient's final diagnosis. Abbreviations U, IU, Q.D., Q.O.D., Trailing zero, Lack of leading zero, MS, MS04, and MgS04 are not to be used in the Medical Record.

(d) A Medical Staff member's pre-printed orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's Medical Record, and shall be dated, timed, and authenticated by the attending physician or other appropriate practitioner.

(e) The following requirements shall be enforced by the Executive Committee:

(1) Histories and physicals must be documented in the Medical Record within 24 hours following admission of the patient. Histories and physicals performed for post-acute inpatient services will adhere to current, applicable Medicare requirements.

(2) All consultations shall contain the date and time of the consultation and shall be documented in the patient's Medical Record as soon as possible.

(3) Progress notes shall be entered into the patient's Medical Record in accordance with Section 5 of this Article.

(4) All operations performed shall be fully described by the operating surgeon who shall record information immediately after the procedure as required by Section 7 of this Article.

(5) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the Medical Record within 72 hours, and the complete protocol shall be made part of the record within a reasonable time.

(f) Where the provisions in this Article conflict with the Medicare requirements for post-acute care inpatient services, such as those involving Skilled Nursing or Inpatient Rehabilitation, and where otherwise not noted, the Medicare requirements will control.

Section 2. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using electronic signatures, and PIN driven signatures. Notwithstanding the foregoing, an original written signature is required on all medication orders that do not use the CPOE.

(b) All entries in the Medical Record shall be dated, timed, and authenticated by the person making the entry.

(c) A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Entries must be individually authenticated as set forth in this section.

Section 3. Contents:

(a) A complete Medical Record for an admitted patient shall include all information as relevant below:

(1) the patient's name, sex, address, date of birth, and authorized representative, if any;

(2) legal status of patients receiving behavioral health care services;

(3) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(4) documentation and findings of assessments;

(5) conclusions or impressions drawn from medical history and physical examination;

(6) the diagnosis, diagnostic impression, or conditions;

(7) the reason(s) for admission or care, treatment, and services;

(8) the goals of the treatment and treatment plan;

(9) evidence of known advance directives;

(10) evidence of informed consent when required by hospital policy;

(11) diagnostic and therapeutic orders;

(12) all diagnostic and therapeutic procedures, tests, and results;

(13) progress notes made by authorized individuals;

(14) all reassessments and plan of care revisions, when indicated;

(15) relevant observations;

(16) the response to care, treatment, and services provided;

(17) consultation reports;

(18) allergies to foods and medicines;

(19) every medication ordered or prescribed;

(20) every dose of medication administered (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and any adverse drug reaction);

(21) every medication dispensed or prescribed on discharge;

(22) all relevant diagnoses/conditions established during the course of care, treatment, and services;

(23) records of communication with the patient regarding care, treatment, and services (for example, telephone calls or e-mail), if applicable; and

(24) patient-generated information (for example, information entered into the record over the Web or in previsit computer systems), if applicable.

(b) Reports of procedures, tests and test results, and other information obtained from outside sources which clearly identify the outside source may be filed with and become an addendum to the patient's record.

(c) All major entries that are dictated and transcribed for entry into the Medical Record shall reflect both the date and time of dictation and the date of transcription.

(d) The Medical Record for children and adolescents shall also include the following:

(1) an evaluation of the patient's developmental age;

(2) consideration of educational needs and daily activities, as appropriate;

(3) the parent's report or other documentation of the patient's immunization status; and

(4) the family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the patient.

(e) All Medical Record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Forms Committee. All new forms proposed for use in the Medical Record shall be submitted to the Forms Committee for approval (or rejection). Approved changes shall not be made until the mechanics of standardization have been accomplished. To the extent permitted by the Committees specified herein, a problem-oriented Medical Record may be substituted for the form specified in Section 3(a) of this Article, so long as the information specified in that Section is included.

(f) The Medical Record should be maintained intact at all times. Once information has been filed in the record, it should not be removed for any reason.

(g) For patients receiving continuing ambulatory care services, the Medical Record will include a summary list of all significant diagnoses, procedures, drug allergies and medications, including known significant medical diagnoses and conditions, known significant operative and invasive procedures, known adverse allergic drug reactions, and known long-term medications, including current prescriptions, over-the-counter drugs, and herbal preparations.

Section 4. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 12 of the Medical Staff Bylaws.

Section 5. Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the Medical Center. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

(b) Progress notes shall be legible, shall document the date and time of observation, and shall contain sufficient information to insure continuity of care at the Medical Center or other health care facility to which the patient might later be transferred.

(c) Progress note documentation shall include, but need not be limited to, the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(2) any complications, new symptoms or additional diagnoses for which the patient is to be evaluated or treated;

(3) plans for additional workups, consultations, or definitive treatment(s); and

(4) discharge planning.

(d) Progress notes can be entered in the Medical Record by Medical Staff members and Medical Associates as permitted by their clinical privileges. Progress notes can be entered in the Medical Record by a Medical Assistant, resident, or nurse when directed to do so by a Medical Staff member.

(e) Progress notes shall be entered at least daily for all patients who have been admitted to the Medical Center. Progress notes entered for post-acute inpatient services will adhere to current, applicable Medicare requirements.

(f) Qualified personnel may document appropriate information in the Medical Record.

Section 6. Surgical and Invasive Procedure Records:

(a) The Medical Record shall thoroughly document operative or other procedures, and the use of moderate or deep sedation or anesthesia.

(b) Except in emergencies, the following data shall be recorded in the patient's Medical Record prior to surgery or other invasive procedure, or the procedure shall be automatically cancelled:

(1) verification of patient identity, the procedure to be performed and the site of surgery;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(4) provisional diagnosis;

(5) laboratory test results, if applicable, including those obtained from sources outside of the Medical Center;

(6) consultation reports;

(7) an appropriately completed and signed consent form;

(8) x-ray reports, if applicable, including those obtained from sources outside of the Medical Center; and

(9) other ancillary reports, if applicable.

(c) Except in the case of an emergency, the patient should not leave for the operating room until the Medical Record is complete or the operating room has received a telephone message that the tests are done but no report has been received.

(d) In an emergency situation, the attending surgeon shall enter a note describing the patient's condition prior to the induction of anesthesia or sedation and the start of surgery. The attending surgeon shall enter a note in the Medical Record stating that the delay for recording the requirements in subsection (b) would constitute a danger to the health or safety of the patient. If the history and physical have been dictated and/or transcribed but not yet entered in the Medical Record, an admission note and statement to that effect may be entered in the Medical Record by the attending physician.

Section 7. Operative Notes and Reports:

(a) A pre-operative note which contains the patient's age, sex, pre-operative diagnosis and recommended surgery, the risks of the surgery, the choice of anesthesia, a pertinent drug history and any allergies shall be documented in the Medical Record before the surgery is to be performed.

(b) A brief operative note shall be entered in the Medical Record immediately after surgery and shall contain significant and pertinent findings.

(c) A detailed operative report shall be entered into the Medical Record or dictated immediately after surgery and shall contain:

(1) a description of the surgery and related findings;

(2) the technical procedures used, including the surgical technique, use of drains, blood and blood components administered, if any, estimated loss of blood and other fluids and replacement. Estimated blood loss does not need to be documented in operative and/or non-operative procedures, if none occurred;

(3) the specimens removed. Specimen(s) removed does not need to be documented in operative and/or non-operative procedures, if none removed;

(4) the post-operative diagnosis;

(5) any unusual events or complications, including blood transfusion reactions and the management of those events;

(6) gross pathology observed visually or by palpation;

(7) the names of the primary surgeon and any and all assistants; and

(8) the type of anesthesia used.

(d) A complete operative report shall be authenticated by the surgeon and entered in the patient's Medical Record as soon as possible thereafter.

(e) When a complete operative report is not entered in the Medical Record immediately after surgery, the appropriate portion of the peri-operative report (or a progress note which includes the following) shall be entered immediately:

(1) name of primary surgeon and assistants;

(2) findings;

(3) technical procedures used;

(4) anesthesia administered;

(5) complications, if any;

(6) specimens removed;

(7) pre-operative diagnosis;

(8) post-operative diagnosis; and

(9) estimated blood loss.

(f) Post-operative documentation shall also include the patient's vital signs, level of consciousness, and medications (including intravenous fluids). Post-operative documentation shall also record the patient's discharge from the post-sedation or post-anesthesia care area by the responsible practitioner according to discharge criteria, and shall record the name of the practitioner responsible for discharge. The use of approved criteria to determine the patient's readiness for discharge shall be documented in the Medical Record.

Section 8. Anesthesia and Sedation Provisions:

(a) A pre-anesthesia or pre-sedation evaluation (for use of moderate to deep sedation) shall be documented in the Medical Record of all patients undergoing surgery and shall include, at a minimum, information relative to the choice of anesthesia or sedative for the procedure anticipated and, where relevant, pertinent drug history and other anesthetic experiences.

(b) A post-anesthesia evaluation shall be documented in the Medical Record of all patients who have undergone surgery. At least one post-anesthesia note shall describe the presence or absence of anesthesia-related complications.

(c) Anesthesia services will be provided under the direction of the chairperson of the Department of Anesthesiology, who shall have oversight responsibilities for the delivery of all anesthesia services.

(d) Requests for privileges to provide anesthesia services will be processed, consistent with all other requests for privileges, as set forth in the Policy on Appointment, Reappointment and Clinical Privileges. The delineation for anesthesia privileges will include the type of supervision, if any, required.

(e) Policies and procedures may be adopted to address specific practices relevant to the delivery of anesthesia services.

(f) All anesthesia services at Hillcrest Baptist Medical Center will be delivered in a "medically directed anesthesia team model" as described by the American Society of Anesthesiologists.

Section 9. Pathology Reports and Disposition of Surgical Specimens:

(a) All specimens removed during a surgical procedure, with the exception of those listed below in Section 9(b), shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite or other areas of the Medical Center as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnoses. Completed surgical pathology slips shall also be sent to the Pathology Department for all surgical or invasive cases in which no specimen, tissue or non-tissue were removed.

(b) At the discretion of the attending surgeon, the following specimens may be exempted from pathologic examination as specified in Section 9(a):

(1) normal skin, skin appendages, cartilage, subcutaneous tissue, scars, teeth, placentas and umbilical cords;

(2) normal tissue removed incidental to cosmetic or reconstructive surgery or incidental to surgical exposure, with the exception of tissue from the breast or tissue removed from a patient with suspected or previous malignancy; or

(3) tubes, drains, sutures and marking devices.

(c) The pathologist shall document the receipt of all surgically removed specimens and shall authenticate the pathology report in the patient's Medical Record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the Medical Record by the

pathologist. The pathology report shall be entered in the Medical Record within 24 hours of completion, if possible.

(d) Foreign bodies and objects may be referred to the Medical Center pathologist at the option of the attending surgeon.

(e) Each surgeon performing surgery or other invasive procedures, whether a specimen is removed or not, shall be responsible for ascertaining that the actual pre-operative diagnosis and the post-operative diagnosis, which may be tentative if depending in part on the pathologic diagnosis, are entered legibly on the surgical pathology slip for that case.

Section 10. Medical Information from Other Hospitals or Health Care Facilities:

Upon written authorization of the patient, the Medical Records Department shall transmit information to other hospitals or health care facilities requesting data concerning the patient's previous admissions, name, birth date, and dates of previous hospitalization. Similarly, the Medical Records Department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient. Reports of procedures, tests and test results, and other information obtained from outside sources which clearly identify the outside source may be entered and become an addendum to the patient's Medical Record.

Section 11. Discharge Summaries:

(a) All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and complications experienced, shall be recorded on the discharge summary, using acceptable disease and operative terminology that includes topography and etiology as appropriate ("Standard Nomenclature of Diseases and Operations"). The discharge summary shall be dated, timed, and authenticated by the attending Medical Staff member at the time of discharge.

(b) A clinical discharge summary shall be entered in the Medical Record within 30 days of discharge for all patients except:

(1) those with minor problems who require less than a 48 hour period of hospitalization;

(2) normal newborn infants; and

(3) uncomplicated obstetrical deliveries.

For patients hospitalized less than 48 hours, a clinical resume (or short-stay form) consisting of a combined admission history, physical, and discharge summary, to include instructions given to the patient or the patient's representatives, shall be acceptable.

(c) The discharge summary shall include:

(1) the reason for hospitalization;

(2) the significant findings;

(3) any complications;

(4) the procedures performed and treatment rendered;

(5) the condition of the patient at discharge;

(6) any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care;

(7) final diagnosis; and

(8) disposition.

(d) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

(e) When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate and a copy of the preprinted instruction sheet used should be on file in the Medical Records Department.

(f) All discharge summaries shall be authenticated by the attending Medical Staff member.

Section 12. Medication Reconciliation:

Medication reconciliation documentation shall be completed and authenticated by an authorized prescriber including any new medication(s) prescribed.

Section 13. Delinquent Medical Records:

(a) All clinical privileges of an individual, to include privileges to admit, treat, give orders, prescribe, consult, perform procedures, make rounds, assist other individuals, or be involved in any way in the care or treatment of patients, shall be automatically relinquished for failure to complete medical records in accordance with the procedure set forth in this Section. Such relinquishment of clinical privileges shall not exempt an individual from responsibility for emergency department call coverage. The individual is responsible for making arrangements for emergency call coverage during this period and for so notifying the Emergency Department. In the event the individual involved fails to make arrangements for emergency call coverage during this period, the individual's failure to arrange for emergency call coverage shall be referred to the Department Chairperson and/or Section Chief and, if unavailable, then to the President of the Medical Staff, who shall arrange for emergency call coverage. Such failure to arrange for emergency call coverage shall constitute an automatic relinquishment of all clinical privileges and resignation from the Medical Staff.

(b) The medical record for each patient shall be complete at the time of the patient's discharge, including the final diagnosis, unless reports of final laboratory work or other reports essential to final diagnosis, noted in the discharge summary, have not yet been received. Patient medical records not completed at discharge shall be completed as soon as possible and within the time frames specified in this Section, with the exception that, in case of patient death and necropsy performed, provisional anatomic diagnoses should be recorded within three days and complete protocol made a part of the record within a reasonable time after patient death. Medical records will be available for completion in the medical records room. An individual who has not completed his or her medical records within the time frames specified in this Section, except as specifically set forth above, shall be considered delinquent and shall be notified of such delinquency in accordance with this Section.

(c) Medical Records Department associates will perform bi-weekly review of patient medical records, and a list will be forwarded to each practitioner of his/her

outstanding records for which he/she is responsible. If medical records remain incomplete at the end of the 30th day post discharge, such fact shall be reported to the Executive Vice President, Chief Medical Officer for the automatic relinquishment of privileges of the attending practitioner.

(d) The Executive Vice President, Chief Medical Officer shall then promptly notify the delinquent practitioner, in writing, by Certified Mail, Return Receipt Requested, of the automatic relinquishment of the practitioner's privileges. The practitioner is given fourteen days from the date of the letter to complete the delinquent records. On the fifteenth day, if the records remain incomplete, the practitioner relinquishes his/her privileges. Such automatic relinquishment of privileges shall continue until such time as all delinquent medical records of such practitioner are complete. At that time, the practitioner's privileges will be automatically reinstated.

(e) No practitioner whose privileges have been automatically relinquished under these provisions and Section 6.D.1 of the Medical Center's Policy on Appointment, Reappointment, and Clinical Privileges shall evade the effect of such automatic relinquishment by having patients admitted under another practitioner's name, however related to the delinquent practitioner, or by any other device or procedure. Any such action shall be brought to the attention of the Executive Committee for appropriate action.

(f) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges six months from the relinquishment shall constitute an automatic relinquishment of all clinical privileges and resignation from the Medical Staff.

(g) Any requests for special exceptions to the above requirements shall be considered by the Medical Records Department with appropriate consultation with the Chief Medical Officer and/or the Executive Committee of the Medical Staff.

(h) No Medical Staff member or other individual shall be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

Section 14. Possession, Access and Release:

(a) All Medical Records are the physical property of the Medical Center and shall not be taken from the confines of the Medical Center. Medical Records may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending physician. Unauthorized removal of a Medical Record from the Medical Center by a Medical Staff member may constitute grounds for a professional review action in accordance with the provisions set forth in the Policy on Appointment, Reappointment and Clinical Privileges.

(b) No patient record shall be removed from the Medical Records Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, Medical Record completion, and/or as needed by the Chief Executive Officer or a designee.

(c) Upon written approval of the Chief Executive Officer after consultation with the President of the Medical Staff, access to the Medical Records of all patients shall be afforded to Medical Staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

(d) Subject to the discretion of the Chief Executive Officer after consultation with the President of the Medical Staff, former Medical Staff members shall be permitted access to information from the Medical Records of their patients covering all periods during which they attended such patients in the Medical Center. Any publication of compiled data from the Medical Center's patient Medical Records is forbidden without written approval of the Chief Executive Officer.

(e) The patient's written consent is required for release of medical information to those not otherwise authorized to receive information.

(f) Any record taken out of the Medical Records Department for the purpose of patient readmission shall be returned with the current record by the charge nurse or a designee on the unit upon discharge of the patient.

(g) In case of readmission of the patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.

Section 15. Filing of Medical Record:

A Medical Record shall not be permanently filed until it is completed by the attending Medical Staff member or is ordered filed by the Quality Improvement Committee. When reports, e.g., laboratory, radiology, etc., are received in the Medical Records Department after discharge of the patient, that Medical Record, with the recently received reports flagged, will be available for the Medical Staff member to review before the record is permanently filed.

ARTICLE IV
CONSULTATIONS

Section 1. General:

(a) Any individual with clinical privileges at this Medical Center may be requested to provide a consultation within his or her area of expertise. Consultation by members or other practitioners associated in the same office should be avoided insofar as possible.

(b) The attending Medical Staff member shall be responsible for requesting a consultation when indicated.

(c) If the history and physical are not part of the patient's Medical Record and the consultation form has not been completed, it shall be the responsibility of the Medical Staff member requesting the consultation to provide this information to the consultant.

(d) If a nurse employed by the Medical Center has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse shall notify the nursing supervisor who, in turn, may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer may bring the matter to the attention of the chairperson of the clinical department in which the member in question has clinical privileges. Thereafter, the chairperson of the department may request a consultation after discussion with the attending Medical Staff member.

(e) In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Executive Committee, the Board, the Chief Executive Officer or the President of the Medical Staff, the appropriate clinical department chairperson shall at all times have the right to call in a consultant or consultants.

(f) It is the duty of the Department Chairperson and the Executive Committee to make certain that Medical Staff members request consultations when needed.

Section 2. Required Consultations:

(a) Consultations shall be required in all non-emergency cases whenever requested by the patient, or the patient's representative if the patient is incompetent.

(b) Consultations are also required in all cases in which, in the judgment of the attending Medical Staff member, unusually complicated situations are present that may require specific skills of other practitioners.

Additional requirements for consultation may be established by the Medical Center.

Section 3. Psychiatric Consultations:

Psychiatric consultation and treatment shall be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's Medical Record.

Section 4. Mandatory Consultations:

(a) When a consultation requirement is imposed by the Executive Committee or the Board, pursuant to the Policy on Appointment, Reappointment and Clinical Privileges, the required consultation shall not be rendered by an associate or partner of the attending Medical Staff member.

(b) Failure to obtain required consultations may result in a further professional review action pursuant to the Policy on Appointment, Reappointment and Clinical Privileges.

Section 5. Contents of Consultation Report:

(a) Each consultation report shall be completed in a timely manner and shall contain an opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's Medical Record. A statement such as "I concur" will not constitute an acceptable consultation report. The consultation report shall be a part of the patient's Medical Record.

(b) Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's Medical Record prior to the procedure. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and be authenticated by the consultant.

ARTICLE V
DISCHARGE

Section 1. Who May Discharge:

Patients shall be discharged only upon an order of the attending Medical Staff member or by a verbal order to be countersigned by the attending Medical Staff member as soon as possible. Should a patient leave the Medical Center against the advice of the attending Medical Staff member, or without proper discharge, a notation of the incident shall be recorded in the patient's Medical Record, and the patient shall be asked to sign the Medical Center's release form.

Section 2. Discharge Planning:

(a) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, which includes an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's Medical Record. The discharge of a patient to another level of care, to different professionals, or to a different setting is based on the patient's assessed needs and the Medical Center's capabilities. The discharge planning process shall address the reason(s) for discharge; the conditions under which discharge can occur; shifting responsibility for a patient's care from one clinician, organization, or service to another; mechanisms for internal and external transfer; and the accountability and responsibility for the patient's safety during transfer of both the organization initiating the transfer and the organization receiving the patient.

(b) Discharge planning shall include, but need not be limited to, the following:

(1) appropriate referral and transfer plans;

(2) methods to facilitate the provision of follow-up care, including communication of the following to the new organization or provider: the reason for discharge; the patient's physical and psychosocial status; a

summary of care, treatment, and services provided and progress toward goals; and community resources or referrals provided to the patient; and

(3) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition; health care needs; the anticipated need for continued care, treatment, and services after discharge; arrangements for services to meet the patient's needs after discharge; written discharge instructions in a form the patient can understand; the amount of activity the patient should engage in; and any necessary medical regimens including drugs, diet, or other forms of therapy.

(c) Sources of additional help from other agencies and procedures to follow in case of complications should also be part of the discharge plan. All such information should be provided by the attending physician.

Section 3. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, person standing *in loco parentis* or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent Medical Record of the patient.

ARTICLE VI

MISCELLANEOUS

Section 1. Disaster Plan:

(a) The Medical Center plan for the care of mass casualties developed by the Critical Care Committee shall be rehearsed in keeping with the Medical Center's policy by key Medical Center personnel, including Medical Staff members.

(b) Each Medical Staff member shall be informed annually of the plan and shall be assigned to designated posts, either in the Medical Center or elsewhere.

(c) The President of the Medical Staff and the Chief Medical Officer, or their respective designees, shall work as a team to coordinate activities and shall give directions. In cases of evacuation of patients from one section of the Medical Center to another, or evacuation from the Medical Center premises, the President of the Medical Staff, the Chief Executive Officer, the Chief Medical Officer or their designees shall authorize the movement of patients.

Section 2. Reports:

It shall be the responsibility of each Medical Staff member to report, in writing and confidentially, to the President of the Medical Staff, the Chief Medical Officer, the Chief Executive Officer or designee any conduct, acts or omissions by Medical Staff members which are believed to be detrimental to the health or safety of patients or to the proper functioning of the Medical Center, or which violate professional ethics or the Medical Staff Bylaws or the Policy on Appointment, Reappointment and Clinical Privileges.

Section 3. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff members shall not discuss with any other individuals the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of Medical Staff committees or departments.

(b) Medical Staff members shall not record or otherwise transcribe the proceedings of such meetings without the unanimous consent of all those in attendance.

(c) Written attendance records shall be maintained for all meetings of the Medical Staff, departments, sections and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of the meetings shall reflect the educational program and clinical review conducted at each meeting.

Section 4. Research Activities:

(a) Participation in research projects by Medical Staff members is encouraged. To ensure adequate compliance with any applicable laws, regulations or guidelines, Medical Staff members shall consult with and obtain the approval of the Chief Executive Officer and the Institutional Review Board regarding any research projects in which they propose to participate.

(b) Policy considerations pertaining to medical and/or scientific research projects of the Medical Staff shall be reviewed by the Executive Committee, the Chief Executive Officer and the Institutional Review Board.

(c) The results of all research projects, clinical, statistical, or otherwise, and all publications written or provided by Medical Staff members using the name of this Medical Center, must be submitted to the Chief Executive Officer and the Institutional Review Board for approval prior to any publication.

(d) Specific protocols shall be followed in the case of any experimental pharmaceuticals to be used. Such protocols shall be submitted to the Pharmacy and Therapeutics Committee and, when appropriate, to the Medical Center's Institutional Review Board for review and approval.

Section 5. Orientation of New Medical Staff Members:

An orientation will be provided by the Medical Center for new Medical Staff members for the purpose of providing information concerning the Medical Center and its environment.

Section 6. Termination of Pregnancy:

(a) In all cases, termination of pregnancy shall be performed consistent with and as authorized by the most recent state and federal statutes and regulations and the guidelines recommended by the Termination of Pregnancy Committee.

(b) Abortion on demand is not done at the Medical Center. All cases in which termination of pregnancy is contemplated will be referred to the Termination of Pregnancy Committee for review and justification or denial.

Section 7. Definitions:

The definitions contained in the Medical Staff Bylaws are hereby incorporated by reference and shall apply to these rules and regulations as well.

ARTICLE VII
AMENDMENTS

(a) Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Medical Center, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Medical Staff Bylaws and the other Medical Staff documents.

(b) An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Executive Committee. Notice of all proposed amendments to these two documents shall be posted on the Medical Staff bulletin board at least 14 days prior to the vote by the Executive Committee. Any voting member may submit written comments on the amendments by the Executive Committee.

(c) The Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Executive Committee. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendments shall stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below shall be implemented.

(d) Amendments to Rules and Regulations may also be proposed by a petition signed by 25% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Executive Committee.

(e) Adoption of and changes to the Medical Staff Rules and Regulations will become effective only when approved by the Board.

ARTICLE VIII

ADOPTION

These rules and regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, policies, manuals or Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: December 10, 2020

By: _____

President, Medical Staff: Richard E. Scott, Jr., DO

Approved by the Board: December 16, 2020

By: _____

Chairman, PI, Credentialing & Patient Safety Committee
HBMC Board of Directors