Texas Health Texas Health Presbyterian Hospital Dallas
Rules & Regulations of the Medical Staff

TABLE OF CONTENTS

TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS
MEDICAL STAFF RULES & REGULATIONS

PURPOSE

Generally, these Rules and Regulations are intended to establish guidelines for the conduct of and processes relating to Medical Staff Members, Advanced Practice Professionals, and Allied Health Professionals who have applied for or been granted Medical Staff appointment, Clinical Privileges, or authorization under a Scope of Service by the Board of Trustees. Nothing in these Rules and Regulations is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital by Members who have been granted Medical Staff appointment and/or Clinical Privileges by the Board of Trustees and/or temporary privileges as provided in these Rules and Regulations. These Rules and Regulations are intended to establish guidelines for the provision of professional services in the Hospital.

CHAPTER 1
ADMISSIONS AND DISCHARGES

1.1 Admissions

Patients shall be admitted to Texas Health Presbyterian Hospital Dallas for inpatient, outpatient, observation or other services only on the orders of a Member who has been granted admitting privileges. Patients should be seen as soon as possible following admission. Patients admitted to an intensive care unit must be seen by the physician writing the order as soon as possible, which is generally expected to be within two (2) hours of admission. Patients admitted to an intermediate level of care (step-down unit) must be seen by the physician writing the order as soon as possible, which is generally expected to be within four (4) hours of admission. Patients transferred from another facility must be admitted to a physician Member who must acknowledge responsibility for the patient by signing a Memorandum of Transfer following the arrival of the patient.

1.2 Unassigned Patients

Patients appearing at the Emergency Department, or applying for admission who have no attending physician, shall be assigned by the Emergency Department physician to a Member in the department to which the patient's illness indicates assignment in accordance with the respective department's emergency department call policy.

1.3 Provisional Diagnosis

Except for emergency admissions, no patient shall be admitted to the Hospital without a provisional diagnosis. The provisional diagnosis for emergency admissions shall be provided as soon as possible following the patient's admission.

1.4 Short Term Admission

Admission for forty-eight (48) hours or less shall be considered a short -term admission, and it is acceptable to use a standard short form medical report for such patients.

1.5 Daily Patient Care

All patients shall be seen at least daily by the physician responsible for directing the patient’s care or his/her designee unless exempted based upon a policy developed by the applicable department and approved by the Medical Executive Committee. An appropriate progress note shall be included in the Medical Record.

1.6 Discharge

A patient shall be discharged from the Hospital by order of the patient's attending physician or his/her designee. The attending physician responsible for directing the patient’s care or his/her designee should be an active participant in the discharge planning process with Hospital staff in order to provide adequately for patient needs post Hospital stay. Where a co-admission requirement exists, a co-discharge shall be required.

A patient transferred to another facility shall be personally examined and evaluated to determine medical need by the physician authorizing the transfer. The physician shall determine and order life support measures as

medically appropriate, determine and order utilization of appropriate personnel and equipment for transfer, and be responsible for securing a receiving physician and Hospital appropriate to the patient's needs. The physician shall comply with documentation requirements for conditions of Memorandum of Transfer per Hospital policy.

CHAPTER 2
DIAGNOSTIC AND THERAPEUTIC ORDERS

2.1 Patient Orders

2.1.1 All orders shall be given and signed by one of the following licensed practitioners:

a. Practitioners with Clinical Privileges.

1) a Medical Staff Member,
2) a Resident in an approved training program,
3) a physician assistant or advanced practice nurse ("Advanced Practice Professional" or "APP") who are authorized to provide patient care at the Hospital.

b. Outside Practitioners.

Orders for the outpatient services listed below may also be given by the following Outside Practitioners:

1) Texas licensed physicians, dentists, and podiatrists who are not members of the Medical Staff, or

2) Texas licensed APPs who are not authorized to provide patient care at the Hospital,

and such Outside Practitioner:

i) is responsible for the patient's care;
ii) must not be on the exclusion list of the federal or state Office of the Inspector General; and
iii) is acting within his/her scope of practice and licensure under Texas law.

c. Outpatient services which Outside Practitioners may order:

1) Phlebotomy for laboratory services;
2) Rehabilitation services (physical therapy, occupational therapy, speech therapy, and cardiac rehab);
3) Imaging;
4) Sleep medicine studies;
5) Patient education and counseling services.

Emergency Department (ED) physicians have privileges to write bridge orders to admit patients and initiate treatment. Such orders are effective at the time the ED physician enters the orders.

2.1.2 Handwritten orders shall be legible. Use of the Member's or APP's ID number in addition to his/her signature should be encouraged.

2.1.3 When ordering a test that requires clinical interpretation, enough relevant information should be provided with the order to inform and guide the interpreting Medical Staff Member concerning what the ordering practitioner is looking to determine.

2.2 Verbal Orders

Verbal orders shall be given by a Member, by Residents in an approved graduate medical education training program or by Physician Assistants or Advance Practice Nurses approved for Advanced Practice Professional status. Verbal orders must be communicated personally to licensed, certified or registered personnel as it

pertains to their licensure or defined scope of service. Verbal orders for application of restraints and for Do Not Resuscitate (DNR) Orders must be signed within 48 hours of the order being given. The date and time must be recorded when signing verbal restraint or DNR orders.

No verbal orders are permitted for Medical Staff consultation or administration of chemotherapy. All other verbal orders must be completed within the time frame for completion of medical records as specified in Section 5.9 of these Rules and Regulations.

Verbal orders may be received and transcribed by a:

Medical Staff Member;
registered professional nurse;
licensed practical nurse;
pharmacist, who may transcribe verbal orders pertaining to his/her area of expertise;
physical therapist, who may transcribe verbal orders pertaining to physical therapy regimens;
respiratory therapist, who may transcribe verbal orders pertaining to respiratory therapy treatments;
registered dietitian, who may transcribe verbal orders pertaining to dietary orders;
medical technologist who may transcribe verbal orders pertaining to laboratory tests; or
licensed social worker who may transcribe verbal orders pertaining to social services.

The individual receiving the verbal order from the Medical Staff Member shall read back the order to the Medical Staff Member to assure accuracy. Verbal orders shall be signed by the individual receiving them and the full name and hospital ID number of the Medical Staff Member who dictated the orders shall be written by the side of the individual's signature. Verbal orders must also include date and time the order was received. The Member, Resident or Allied Health Professional shall sign the verbal order. Members of the Resident Staff may also give orders for any patients under the direction of members of the Medical Staff who have not been specifically exempted as teaching or service patients. Nothing in this or any other section shall prohibit the any Medical Staff Member involved in the patient's care from giving orders for a patient who is a teaching service patient

2.3 Consultation

The attending physician is primarily responsible for requesting a consultation from a Member as appropriate, and as required by the bylaws, the Medical Staff, or the Hospital policies. Judgment as to the correct diagnosis treatment or the severity of illness generally rests with the physician responsible for directing the course of the patient's treatment. Any Member of the Medical Staff who has been granted appropriate Clinical Privileges at the Hospital may be called as a consultant regardless of his/her staff category assignment.

Consultation should be performed within twenty-four (24) hours or less depending on the nature and severity of the patient's condition.

2.4 Pre-Printed and Standing Orders

Medical Staff Members may develop standardized admission orders for patients with common provisional diagnoses. However, such orders shall be made specific for each individual patient before being implemented for that patient.

Standing orders may be developed for special care areas or for life-threatening situations. All standing orders shall be developed in cooperation with Nursing Service, other services, and Administration as appropriate, and must be approved by the appropriate Process Improvement Committee and the Medical Executive Committee. The MEC shall provide for periodic and regular review in conjunction with the medical staff, nursing, and pharmacy leadership.[1]

2.5 Transfer Orders

When a patient goes to surgery or is transferred to another service or another level of service, all orders must be re-entered in the electronic health record including resuscitation orders, medications, etc. , all previous orders, except Do Not Resuscitate orders, are automatically canceled. Previous medication orders may be resumed in the EHR

[1] CoP 482.24(c)(3)

Investigational Drugs and devices shall be handled in strict compliance with FDA regulations. Physicians, dentists, oral surgeons and podiatrists shall obtain approval for the use of investigational drugs and devices through the Texas Health Resources Institutional Review Board. Such drugs shall be dispensed from the Hospital Pharmacy upon the authority of the investigator authorized to conduct the study. Drugs administered to patients in the Hospital must be obtained from the Hospital Pharmacy.

2.6 Drug Standards

Drugs used shall, as a minimum standard, meet the requirements of the U.S. Pharmacopoeia, National Formulary, New and Non-official Drugs, with the exception of drugs for approved clinical investigations. Additional standards may be required by the Pharmacy and Therapeutics Committee. Patients may continue medications prescribed prior to Hospitalization as long as their physician has been so notified and gives an order to that effect consistent with Pharmacy and Therapeutics Committee policy and all such medication is noted in the medical record. All such drugs should be identified by a Hospital pharmacist.

Investigational Drugs and devices shall be handled in strict compliance with FDA regulations. Physicians, dentists, oral surgeons and podiatrists shall obtain approval for the use of investigational drugs and devices through the Texas Health Resource's Institutional Review Board. Such drugs shall be dispensed from the Hospital Pharmacy upon the authority of the investigator authorized to conduct the study. Drugs administered to patients in the Hospital must be obtained from the Hospital Pharmacy.

2.7 Admission Laboratory Procedures

There are no requirements for routine laboratory work on admission to the Hospital. Laboratory results, if done in a licensed laboratory (State license) and within seven (7) days of the admission may at the discretion of the attending physician and/or anesthesiologist, be incorporated into the patient record.

2.8 Progress Notes

Pertinent progress notes shall be entered in the record at the time of observation, sufficient to permit continuity of care and transferability. All patients shall be seen daily and as soon after admission as is deemed appropriate. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with a specific order as well as with results of tests and treatments. The practitioner responsible for directing the patient's care or his/her designee should see each hospitalized patient daily and document the patient's progress in the medical record for appropriate management of the patient's medical condition.

When a Resident, Physician Assistant or Advanced Practice Nurse performs a procedure normally thought of as care that would be given by a physician, the documentation in the progress notes must be countersigned by a physician.

CHAPTER 3
SPECIAL TREATMENT PROCEDURES

3.1 Restraints

Only a physician may order the use of restraints. Guidelines and specific procedures for the use of restraints are defined in Hospital policy, which is available from the nursing/departmental supervisor on all patient care units and all patient procedural areas The Department of Neurology & Psychiatry maintains a separate policy for restraints incorporating different regulatory requirements governing the use of restraints in this special patient population.

3.2 Seclusion

Seclusion, which is defined as placement of a patient alone in a room, may only be employed on the psychiatry inpatient unit by physician order according to the provisions of the restraint/seclusion policy approved for the Department of Neurology & Psychiatry.

3.3 Electro-Convulsive Therapy/Treatment

The policies governing the use of electro-convulsive and other forms of convulsive therapy are available online. Electro-convulsive therapy/treatment is restricted to appropriately credentialed physicians in the Department of Psychiatry with privileges to perform these procedures.

CHAPTER 4
SURGICAL PROCEDURES

4.1 Consent Required

It is the responsibility of each Member to obtain the informed consent from the patient or his/her legal representative, except in emergencies, prior to the commencement of a procedure or patient transfer to another facility. The Member shall document the risks, benefits and alternatives to treatment in accordance with Hospital policy. Patient permission should be obtained for any vendor or outside party to be present in the procedure or in the operating room in accordance with Hospital policy.

4.2 Assistant Required

The operating surgeon shall have a qualified assistant surgeon during all procedures as determined by departmental policy. Each policy shall be submitted to and approved by the Medical Executive Committee.

4.3 Specimens

All specimens removed during a surgical or other invasive procedure shall be sent to the Hospital laboratories for examination unless exempted under established criteria for surgical specimens that do not require examination by Pathology. Such exemption shall be approved by the Medical Executive Committee.

4.4 Anesthesia Care

An Anesthesiologist, physician member of the Medical Staff, or Certified Registered Nurse Anesthetist will maintain a complete anesthesia record. See Chapter 5, Medical Recordkeeping.

4.5 Follow-up Care

The follow-up care of the patient throughout the immediate postoperative period is the responsibility of the operating surgeon or his/her qualified designee.

CHAPTER 5
MEDICAL RECORDKEEPING

5.1 Hospital Records

All medical records are the property of the Hospital and shall not leave the premises of the Hospital except upon receipt of a court order, subpoena, or statute. Release of medical records at the patient's request shall require consent for release of these records in accordance with Hospital policy.

5.2 Medical Records Information

5.2.1 It is the responsibility of the attending Practitioner to prepare a complete and accurate medical record for each patient.

The medical record shall include identification data, complaint, history of present illness, past medical history, family history, system review, physical examination, diagnostic and therapeutic orders, special and procedural reports (such as consultation, clinical laboratory, x-ray reports, and others), clinical observations, provisional diagnosis, medical or surgical treatment, operative reports, progress notes, final diagnosis, condition on discharge, discharge summary, follow-up or autopsy report when available. [2]

5.2.2 No medical record shall be filed until it is complete, except on order of the Clinical Information

[2] Medicare Conditions of Participation (CoP) 42 CFR Sec. 482.24(c); CMS State Operations Manual (SOM) A-0449.

Committee. It is the function of the Medical Executive Committee to promulgate specific rules and regulations to the extent of suspension of admitting privileges and/or staff privileges to assure the timely completion of records both for documentation and for timely submission of various claims for payment by the Hospital.

5.3 History and Physical Examination

5.3.1 Admission; Readmission within 30 Days.

A history and physical examination (H&P) must be in the electronic health record, on all patients undergoing surgery or other procedure requiring anesthesia no more than thirty (30) days prior to admission and no later than twenty-four (24) hours following admission.

The H&P also must be in the electronic health record before any surgery or procedure requiring anesthesia is performed unless the surgeon documents in the medical record that any delay to record the H&P would be a hazard to the patient. [3]

For emergency admissions, a brief description of the patient's condition should be immediately entered in the record pending completion of the H&P.

5.3.2 If an H&P has been performed within the thirty (30) days prior to admission, the H&P report or a legible copy of the report may be used provided the H&P is updated and the following are noted in the electronic health record or on the H&P within twenty-four (24) hours after admission but prior to surgery or any procedure requiring anesthesia:[4]

a. the H&P was reviewed;
b. the patient was examined;
c. any changes in the patient's condition since the time the H&P was performed that might be significant for the planned course of treatment;
d. If there are no changes, the statement "nothing has changed" or "no changes" will be documented and the H&P re-dated and signed.

Any H&P performed over thirty (30) days prior to admission will not be accepted.

5.3.3 The H&P (including any updated H&Ps) must be completed by a physician or Advanced Practice Professional with appropriate Clinical Privileges. An H&P completed by a physician who is not a Medical Staff Member may be used and included in the patient's medical record provided it is signed by the admitting physician and/or updated in the electronic health record.

5.3.4 Content. The H&P must meet Hospital guidelines as to content and timeliness and shall contain at least the following information regardless of format, e.g. recorded in a transcribed report, entered in CareConnect, or included in a doctor's office record:

- date of assessment;
- chief complaint;
- details of present illness;
- past medical history including previous surgery;
- social history;
- family history;
- review of systems;
- physical examination to include at least three distinct organ systems;
- vital signs;
- current medications and allergies;
- diagnosis/clinical impression/conclusions;
- plan of treatment/course of actions;
- physician signature.

[3] CoP 42 CFR Sec. 482.24(c)(4); CMS SOM A-0458.

[4] CoP 42 CFR Sec. 482.24(c)(4); CMS SOM A-0461

5.3.5 Outpatients and observation patients. An H&P shall be obtained for outpatients prior to an outpatient invasive procedure requiring anesthesia or within 24 hours after admission for patients admitted for observation.

5.3.6 Abbreviated, tailored content for H&Ps. The Medical Executive Committee may approve abbreviated or tailored content for an H&P for use prior to an outpatient procedure when requested by a clinical department. Any request for an abbreviated or tailored H&P must be submitted to the Clinical Information Committee for approval and referral to the Medical Executive Committee.

5.3.7 An adequate admission note shall be written upon admission.

5.3.8 Refer to Hospital policy for other requirements relating to H&Ps, e.g. specific patient types, signature of H&Ps.

5.4 Consultations as History and Physical

Consultations may be used as a history and physical exam if they are recorded or dictated within twenty-four (24) hours after the patient's admission and if they are adequate in content.

5.5 Care of Surgical Patients

Except in an emergency, it is the responsibility of the Member performing the surgery to see that the patient's medical history and physical exam, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record prior to surgery or other procedure requiring anesthesia services. In the case of an emergency, any required information not recorded prior to surgery shall be recorded in the medical record as soon as possible following the surgery.

5.5.1 Pre-anesthesia, pre-sedation evaluations.[5]

Any patient for whom general or regional anesthesia or monitored anesthesia care is planned must have a pre-anesthesia evaluation completed within forty-eight (48) hours prior to surgery or other procedure requiring anesthesia. An anesthesiologist, other Medical Staff Member, or CRNA with privileges to administer the anesthesia must perform the evaluation.

A pre-sedation evaluation is required for moderate and deep sedation but is not required to be completed within forty-eight (48) hours or any other time period.) [6]

The pre-anesthesia evaluation for general, regional, and monitored anesthesia should include at a minimum:

a. Review of the medical history, including anesthesia, drug and allergy history, interview, if possible given the patient's condition, and examination of the patient;

b. Interview and examine the patient, if possible given the patient's condition;

c. Notation of anesthesia risk, e.g. ASA classification of risk;

d. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure, e.g. difficult airway, ongoing infection, limited intravascular access;

e. Additional pre-anesthesia data or information, if applicable prior to administration of anesthesia, e.g. stress tests, additional specialist consultation; and

f. Development of the plan for the patient's anesthesia care including the type of medications for induction, maintenance, and post-operative care and discussion with the patient or patient's representative of the risks and benefits of the delivery of anesthesia.

[5] 42 CFR 482.52(b)(1); CMS SOM A-1003.

[6] TJC PC .03.01.03; RC.02.01.01.

5.5.2 Anesthesia report. [7] There must be an intraoperative anesthesia record or report for each patient who receives general, regional, or monitored anesthesia. The report should include the following:

a. Names of Practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner;

b. Name, dosage, route, and time of administration of drugs and anesthesia agents;

c. Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

d. Name and amounts of IV fluids, including blood or blood products if applicable;

e. Vital signs as well as oxygenation and ventilation parameters; and

f. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

5.5.3 Post-anesthesia evaluation. [8]

a. A post-anesthesia evaluation shall be completed and documented by an anesthesiologist, other Medical Staff Member, or CRNA with privileges to administer anesthesia.

For inpatients, a post anesthesia evaluation must be completed and documented within forty-eight (48) hours following surgery or other procedure requiring anesthesia. For outpatients, the post anesthesia evaluation shall be performed prior to discharge and as close to discharge as feasible.

b. The post-anesthesia evaluation should include the following:

- respiratory function, including respiratory rate, airway patency, and oxygen saturation level;
- cardiovascular function, including pulse rate and blood pressure;
- mental status;
- temperature;
- pain;
- nausea and vomiting; and
- postoperative hydration.

5.5.4 Operative Reports.

The primary surgeon shall enter or dictate an operative report after the surgery or other high-risk procedure upon completion of the procedure and before the patient is transferred to the next level of care. However, if the Member who performed the procedure goes with the patient to the next level of care, the report may be entered while in the new unit or level of care.[9] In such case, the Member should include in the report that he/she traveled with the patient to the next level of care."

When an operative report is dictated, the Member shall enter a n immediate post-operative note in the electronic health record following the procedure. (See Section 5.5.5 below for additional information.)

Operative reports shall provide sufficient information about the surgical procedure and the patient's condition to facilitate care in the immediate post-operative period.

[7] 42 CFR 284.52(b)(2); CMS SOM A-1004.
[8] 42 CFR Sec. 482.52(b)(3); CMS SOM A-1005, DSHS 25 TAC 133.41(a)(2)(C).
[9] TJC RC.02.01.03

Operative reports should contain the following information at a minimum: [10]

- date and time of surgery;
- name of the primary surgeon, anesthesiologist and any assistants or other practitioners (even when performing those tasks under supervision);
  - pre-operative diagnosis;
  - type of anesthesia or analgesia used;
  - the specific technical procedure(s) performed and description of the procedure[11];
  - any prosthesis, material, graft, transplant, or device inserted into the patient;
  - description of anatomical findings;
  - specimens removed;
  - a description of the techniques, findings, and tissues removed or altered[12];
  - any complications, untoward or unanticipated events or conditions, and the management of such events;
  - any estimated blood loss;
  - post operative diagnosis;
  - physician signature.

5.5.4.1 Primary Suspension for Operative Report delinquencies

Operative Reports not available in the medical records within twenty-four (24) hours of completion of the procedure will cause the Member to be placed on Primary Suspension.

-Physician will receive telephone notification of delinquencies on the next business day after the operative report entry was due ("Telephone Notice").

-If the Operative Report is not completed by 8:00 a.m. on the first business day following the Telephone Notice, the Physician will be placed on Primary Suspension automatically.

-The HIM department will send notice to the Physician ("Primary Suspension Notice") via email or fax notifying him/her of the Primary Suspension and that Full Suspension will be imposed if delinquent entries are not completed within fourteen (14) days of imposition of Primary Suspension.

-Notice will also be sent to the Hospital Medical Staff Office.

-A Physician who remains on Primary Suspension for fourteen (14) days without completion of the delinquencies shall automatically be placed on Full Suspension. Notice will be sent to the Physician and to the Hospital Medical Staff Office via email or fax.

-Physicians placed on Primary Suspension may not:

-Admit patients (except for previously scheduled admissions or elective surgery)

-Schedule elective surgery for new inpatients or outpatients

Physicians placed on Primary Suspensions may:

-Admit emergent patients

-Continue to provide care for all patients admitted prior to the date of suspension

-Continue with previously scheduled admissions or elective surgeries

-Shall fulfill his/her emergency room call rotation obligation

5.5.5 Post-Operative progress note. [13]

When a full operative report cannot be entered immediately after the procedure, a post-operative progress note must be entered in the electronic health record before the patient is moved to the next level of care.

Post-operative notes shall contain the following information at a minimum:

- name of the primary surgeon and his/her assistants;
- preoperative diagnosis;
  - post-operative diagnosis;
  - surgical findings;
  - procedure(s) performed;

[10] 42 CFR Sec. 482.51(b)(6); CMS SOM A-0959

[11] JC RC 02.01.03 EP 6

[12] DSHS, 25 TAC Sec. 133.41(w)(2)(F).

[13] JC RC 02.01.03 EP7.

- technical procedures;
- specimens removed;
- estimated blood loss; and
- operating Practitioner's signature.

5.5.6 The medical record also contains the following post-operative information:

- the patient's vital signs and level of consciousness;
- any medications, IV fluids;
- any administered blood, blood products, and blood components; and
- any unanticipated event or complications (including blood transfusion reactions) and the management of those events.

5.6 Consultations

5.6.1 Reports of all consultations on the patient must be promptly filed in the patient's medical record.

5.6.2 If the report is not immediately available, a brief consultation note shall be promptly documented in the medical record and contain, at a minimum, pertinent information for anyone required to attend the patient. [14]

5.7 Readmission within 30 days

If the patient is re-admitted within thirty (30) days for the same or related problem, an interval history and physical examination may be used provided that the original information is available.

5.8 Access to Records

Access to all medical records of all patients shall be accorded to staff physicians in good standing and who have a medical need to know or fulfill a staff responsibility, preserving the confidentiality of personal information concerning individual records of the patient. Subject to the discretion of the Hospital President, former members of the Medical Staff shall be permitted access to the medical records of their patients concerning all periods during which they attended the patients in the Hospital.

5.9 Symbols and Abbreviations

The Hospital uses abbreviations and symbols from Stedman's Medical Dictionary and The Joint Commission "Do Not Use" List of Abbreviations as a reference guide.

5.10 Authentication and Correction

5.10.1 All entries in the patient's medical record including orders and verbal orders shall be dated, timed, and authenticated by the ordering Medical Staff Member/APP or other Member or APP responsible for the patient's care. [15] Electronic signatures are considered an appropriate form of authentication.

5.10.2 Histories and Physicals and discharge summaries performed by medical residents must be countersigned by the attending or supervising physician.

5.10.3 Members may sign medical records for their Member partners as long as the signing Member has been involved in the care of the patient whose record is being signed.

5.10.4 Any change or addition in a medical record shall be clearly marked as an addendum or change, and signed, dated and timed by the Practitioner.

5.10.5 Use of electronic signatures are allowed as specified in these Rules & Regulations and Hospital policy. The use of signature stamps is not permitted.

[14] CoP 42 CFR Sec. 484.24(c)(4)(iii); CMS SOM A-0464.

[15] CoP §482.24(c)(1); SOM A-0450.

5.11 Completion of Medical Records and Hospital Required Clinical Information

5.11.1 The medical record of a discharged patient shall be completed within 14 days following discharge. The failure to complete a medical record within 14 days after discharge shall result in automatic suspension of the Member's admission privileges except for emergency admissions. Suspension of privileges shall be in accordance with the Medical Staff Bylaws, Section 5.11.2 below, and any policy approved by the Medical Executive Committee to implement these rules.

The above rule shall also apply when the Hospital requests clinical information post discharge to comply with mandatory reporting requirements placed on the Hospital for accreditation purposes, and/or to comply with state and/or federal law and regulations.

5.11.2 Failure to Complete Medical Records or to Provide Hospital Required Clinical Information.

A Member who has one or more incomplete medical records or fails to respond to the Hospital's request for information under Section 5.11.1 will be advised of this after seven (7) days. If records remain incomplete after fourteen (14) days, they shall be delinquent and all admission privileges except for emergency admissions will be automatically suspended. A Medical Staff Member with a medical records suspension for more than thirty (30) days may be required to meet with the Clinical Information Committee or other appropriate Medical Staff committee in accordance with Section 9.2.7 of the Medical Staff Bylaws.

The Member must complete all incomplete records for the suspension to be lifted.

Automatic suspensions for incomplete medical records will be reported to the Medical Executive Committee. Exceptions for enforcement of this Rule & Regulation shall be allowed only on the written approval of the Department Chair or his/her designee in those situations patient care could be adversely affected.

The Practitioner's Clinical Privileges shall be automatically terminated along with Medical Staff membership if the Practitioner remains on automatic suspension for more than 90 consecutive days.

5.11.3 Progressive interventions.

a. One to three Medical Record Suspensions in a Rolling Twelve-Month Period.

Notification will be sent to the Member for each of the suspension(s).

The appropriate Department Chair will be notified upon suspension. Following a third (3rd) medical record suspension in a rolling twelve (12) month period, the Member shall be required to meet with the Clinical Information Committee using the procedures in Section 9.2.7 of the Medical Staff Bylaws.

b. Four medical record suspensions in a Twelve-Month Period.

Following a fourth (4th) medical record suspension in a rolling twelve (12) month period, the Department Chair will be notified, and a letter of reprimand will be sent to the Member in question. The Member will be advised that inquiring facilities will be notified of the Member's repeated failure to complete his/her assigned medical records, e.g. when a Member applies for privileges at another facility. This information will be made available to the Credentials Committee at the time of reappointment.

c. Six Medical Record Suspensions in a Twelve-Month Period.

Following a sixth (6th) medical record suspension in a rolling twelve (12) month period, the Member will be required to attend a formal meeting with the Medical Executive Committee using the procedures in Section 9.2.7 of the Medical Staff Bylaws. Failure to meet with the Medical Executive Committee may result in a recommendation to the Medical Executive Committee that his/her name is being referred to the appropriate licensing agency.

d. Seven or more Medical Record Suspensions in a Twelve-Month Period.

Following the Member's meeting with the Medical Executive Committee, if the Member has a seventh (7th) medical record suspension within a rolling twelve (12) month period, the Member's membership and Clinical Privileges will be automatically terminated.

5.12 Discharge Summary; Final Diagnosis

5.12.1 Discharge summary. [16]

a. All medical records (both inpatient and outpatient) must include a discharge summary and must be entered into the electronic health record within twenty-one (21) days. The discharge summary (or a short-stay summary for patients hospitalized less than 48-hours) shall be dictated or created and entered in the electronic health record.

A Member or Advanced Practice Professional responsible for the patient's care during the hospital stay or outpatient visit shall enter the discharge summary. A Member who delegates authority to an APP to prepare the discharge summary must co-authenticate and date the discharge summary.

b. The discharge summary should provide information to other caregivers and facilitate continuity of care including the following:

1) the reason for the hospitalization;
2) the outcome of the hospitalization (e.g. the treatment, procedure, or surgery);
3) the disposition of the case;
4) final diagnosis;
5) the patient's condition at discharge; and
6) provisions for follow-up care, if applicable.

5.12.2 The Medical Staff Member shall include a final diagnosis in the electronic health record.

5.13 Notifications

5.13.1 Health Information Management will contact the Medical Staff Member with the incomplete medical record(s) regarding medical record deficiencies and suspensions by one of the following methods:

a. Electronic notification: In-basket electronic health record message;
b. Fax transmission;
c. Phone call; or
d. Notice by regular mail.

5.13.2 It is the responsibility of the Member to notify the Medical Staff Services and Health Information Management of any changes in contact information.

5.14 Coding Queries

The Hospital may send a coding query to a Member to clarify documentation in the medical record. The Member must respond to the coding query within seven (7) days after receiving the query in the Member's in-basket in the electronic health record.

It is the expectation that the Member respond to the query by either documenting a progress note in the electronic health record clarifying the documentation or declining the query and stating the reason for declining.

[16] CoP §482.24(c)(4)(vii); SOM A-0468

CHAPTER 6
SUPERVISION OF RESIDENT STAFF

6.1 Teaching Programs

Consistent with the sponsorship of an Accreditation Council on Graduate Medical Education approved residency training program and Affiliation Agreement for residency training programs, it is necessary and desirable to conduct medical education programs within the Hospital. The Medical Education Committee shall develop guidelines for inclusion of patients in teaching programs and for supervision of medical care within the Hospital's Medical Education Program. Such guidelines shall be submitted to the Medical Executive Committee of the Medical Staff for approval.

Pelvic Surgery Fellowship. The Pelvic Surgery Fellowship is a non-accredited fellowship generally for one year. The selected visiting physician ("Fellow") is only eligible for clinical privileges as necessary to carry out the duties and the functions of the pelvic surgery fellowship so long as the Fellow continues in that role. At the end of the fellowship, the clinical privileges automatically terminate.

6.2 Supervision Requirements for Teaching Service Patients

Attending Staff, who are faculty in an approved residency program, shall supervise the care of all teaching service patients in a manner that is consistent with the ACGME requirements for the applicable residency program. Supervision shall be structured to provide trainees with progressively increasing responsibility commensurate with their level of education, ability and experience. The patient's immediate care shall be performed by the resident whenever possible. Attending Staff are expected to be available to assist residents in the care of the patient at all times. Attending Staff with supervisory responsibilities for teaching service patients must countersign history and physical examinations and discharge summaries documented by the resident staff for teaching service patients.

Teaching service patients shall be assigned to the department or section concerned in the treatment of the disease which necessitated the admission. Participation in teaching programs is one criterion upon which continued good standing on the Medical Staff is based. In those departments and services conducting Graduate Medical Education programs, records may be kept indicating the degree and kind of participation in educational activities by each member of the practicing staff.

6.3 Supervision Requirements for Private Patients

All private patients will be eligible for the teaching services, but private patients shall be treated by their own private physicians, who shall continue as the primary physician and provide supervision to the Resident. A physician may exempt a patient from the teaching service when he/she believes it is in the patient's best interest or welfare. This may include the number or proportion of admissions to teaching services.

6.4 Patient Orders

Members of the Resident Staff may also give orders for any patients who have not been specifically exempted as teaching or service patients under the direction of members of the Medical Staff. Nothing in this or any other section shall prohibit the physician, dentist, oral surgeon and/or podiatrist involved in the patient's care from giving orders for a patient who is a teaching service patient.

CHAPTER 7
GENERAL

7.1 Identification Badges

Members and credentialed Advanced Practice and Allied Health Professionals under the supervision of Members shall wear identification badges issued by the Hospital for security and identification purposes when providing services in the Hospital.

7.2 Continuous Physician Coverage

A physician who anticipates being unavailable must provide for coverage by another physician whose Hospital privileges permit him/her to treat the patient(s) whom he/she may be covering and who will be responsible for

care of the patient(s) during his/her absence. The name of the physician who will be responsible for the patient(s) in the attending physician's absence will be listed with the physician's telephone exchange. In case of failure to name such an alternate, the following

(a) Chair of the Department or in his/her absence, the Vice-Chair;

(b) the President of the Medical Staff or his/her designee; or

(c) the Hospital President or his/her designee

will have the authority to call a qualified consenting Member to care for the patient in such an event.

7.3 Response to Pages and Telephone Calls

Members and Advanced Practice and Allied Health professionals under the supervision of Members are expected to respond to pages and/or telephone calls from patient care areas of the Hospital as quickly as possible but within thirty (30) minutes of receiving the message from the paging service or other voice recording on Member's phone number provided to staff. Pages designated as "Stat" should be returned in five (5) minutes.

7.4 Response to Requests of the Emergency Department

Refer to Trauma policy for Trauma response guidelines.

The physician who is providing on-call services ("On-Call Physician") must evaluate every patient with a medical emergency condition that is requested of the On-Call Physician by the Emergency Department ("ED") for observation, consultation or admission services. The medical emergency is deemed by the Emergency Department Physician. The On-Call Physician is expected to respond to the call from the ED within thirty (30) minutes. "Respond" is defined as presenting oneself to the ED or telephoning the ED and speaking to the ED physician. If the On-Call Physician does not respond within the appropriate amount of time as judged by the ED physician caring for the patient, the ED physician will call the On-Call Physician's designated alternate to provide the needed service, if any. If the designated alternate is unavailable or is not identified, the department chair for such clinical service will be requested to resolve the issue. The ED will submit an occurrence report to the On-Call Physician's clinical service department chairman and the Hospital's Chief Medical Officer noting the failure to timely respond.

If the ED physician request that the On-Call Physician come to the ED to examine/treat a patient, the On-Call Physician must do so within thirty (30) minutes, even if the On-Call Physician does not agree with the ED physician's assessment. If a mutually agreeable plan for care can be achieved over the phone, it is permissible to manage the patient using the ED physician as a proxy, but otherwise, the ED physician's judgement prevails.

If an On-Call Physician is contacted regarding a request from another facility to evaluate the circumstances around a requested transfer to the Hospital, the On-Call Physician must respond within thirty (30) minutes to discuss and evaluate the clinical information provided by the transferring facility. The Hospital will determine whether it has the capacity to accept a transfer and the On-Call Physician will inform the Hospital whether he/she has the requisite clinical expertise to appropriately support the transfer. The On-Call Physician is required to accept or consult the transfer of a patient with an emergency medical condition at another hospital's emergency department if the On-Call Physician has the capability to care for the patient.

On-Call Physicians who provide call coverage to multiple facilities simultaneously are responsible for ensuring the availability of backup coverage should conflicting clinical responsibilities impede his/her ability to respond in a timely manner. Back up coverage must be by a physician with similar qualifications and clinical privileges at the Hospital.

Any failure by an On-Call Physician to not comply with this Section 7.4 may be grounds for corrective action by the Medical Staff or separate action by the Hospital.

7.5 Disaster Plans

Each Member shall comply with the Emergency Preparedness Plan approved by the Medical Executive Committee and the Board of Trustees. Such internal and external disaster plans shall be formulated by the Emergency Preparedness Committee.

7.6 Utilization Review

Patients with extended hospitalization should have the reasons documented by the physician responsible for directing the overall care of the patient in the progress notes. Discharge planning should be initiated as soon as the need for such services is determined.

7.7 Death of Hospitalized Patient

In the event of the death of a hospitalized patient, the patient will be pronounced dead within a reasonable time by the physician responsible for directing the overall care of the patient, his/her physician designee, or a registered nurse caring for the patient, when the criteria defined under state law regarding pronouncement have been met. For procedures regarding the release of a deceased patient's body, refer to Administrative Policy Section III, Procedure 16A, *Release of Bodies to Funeral Home from the Morgue* and Administrative Policy Section III, Procedure 16B, *Release of Bodies to Funeral Homes from the Floor*.

7.8 Qualified Medical Personnel for Conducting Medical Screening Examinations

A "Qualified Medical Personnel" who may conduct a medical screening examination in the Emergency Department ("ED") is a person who provides medical coverage services in the ED and who is either a Member of the Medical Staff ("Member") or member of the Advance Practice Professional Staff.

With respect to psychiatric assessments in the Emergency Department or a behavioral health unit, "Qualified Medical Personnel" means either a member of the medical staff of Hospital or any of the following licensed behavioral health providers who have been granted Clinical Privileges: Psychologists (Ph.D., PsyD), Registered Nurses, Master's prepared Social Workers (LCSW, LMSW), Licensed Professional Counselor (LPC, LPC Intern), and Licensed Marriage and Family Therapist (LMFT, LMFTA). Each Psychologist, Registered Nurse, Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist who serves as Qualified Medical Personnel shall have received training on what constitutes an appropriate psychiatric assessment.

In the Labor & Delivery Department, Qualified Medical Personnel may be either a Member with obstetrical privileges, Certified Nurse Midwife or a registered nurse in the Labor & Delivery Department who has received training on what constitutes an appropriate medical screening exam.

A physician shall perform medical screening exam of an obstetrical patient if: 1) the patient is being considered for transfer to another facility; 2) the RN, based upon the assessment findings, asks for a physician to evaluate the patient during admission or prior to discharge; or 3) the patient asks to be examined by a physician.

CHAPTER 8
AUTOPSIES

8.1 Autopsies

Each Member shall be encouraged to request autopsies when appropriate. Autopsies are usually performed by a hospital-based Pathologist, or his/her Member designee, and shall not be done without proper written consent. Attendance at autopsies is encouraged and the Pathology Department will notify the attending physician of the time of the autopsy and post notices of scheduled autopsies whenever possible. The procedure for requesting an autopsy is defined in Administrative Policy Section III, Procedure 8, *Procedure for Autopsy Authorization*.

CHAPTER 9
ORGANIZED HEALTH CARE ARRANGEMENT

9.1 Organized Health Care Arrangement

The Board of Trustees of Texas Health Presbyterian Hospital Dallas has adopted a policy to act as an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Privacy Act of 1996 (HIPAA) and in accordance with the Texas Health Resources Organized Health Care Arrangement Policy. The Medical Staff of Texas Health Presbyterian Hospital Dallas acknowledges its participation with Texas Health Presbyterian Hospital Dallas in an Organized Health Care Arrangement with respect to jointly managed patients. Each Member agrees to abide by the terms of the Hospital's *Joint Notice of Privacy Practices*, and the underlying Hospital privacy policies, with respect to Protected Health Information (PHI) created or received as part of participation in the OHCA. As stated in the OHCA policy, each participant is individually responsible for compliance and the compliance of any privately employed personnel with the Notice and its underlying policies. The Notice will not cover PHI created or received by individual members of the Medical Staff solely in their office setting. The Notice required by the statute and the policy will be administered by Hospital personnel for all Hospital-based episodes of care, including inpatient and outpatient treatment.

MEDICAL STAFF RULES & REGULATIONS:

Medical Executive Committee	February 2024
Medical Staff	February 2024
Board of Trustees	February 2024
Effective	February 2024