RULES AND REGULATIONS

OF THE MEDICAL STAFF

TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH
1301 Pennsylvania Avenue
Fort Worth, TX 76104

Adopted November, 1931
including all Amendments
approved by the Board of Trustees
September 29, 2021

HARRIS METHODIST FORT WORTH
MEDICAL STAFF RULES AND REGULATIONS
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1.0 INTRODUCTION

1.1 General

The following Rules and Regulations have been adopted by the Medical Staff and BOT with the expectation that the matters contained herein will enhance patient care and the orderly administration of the Hospital.

1.2 Enforcement and Discipline

The Medical Board shall have the authority to impartially enforce these Rules and Regulations and shall monitor compliance with these Rules and Regulations, in the best interest of patient care and the orderly administration of the Hospital.

1.3 Organized Health Care Arrangement

The governing board of Texas Health Harris Methodist Hospital Fort Worth has adopted a policy to act as an Organized Health Care Arrangement (OHCA) under the Health Information Portability and Privacy Act of 1996 (HIPPA) and in accordance with the THR Organized Health Care Arrangement Policy. The medical staff of Texas Health Harris Methodist Hospital Fort Worth acknowledges its participation with Texas Health Harris Methodist Hospital Fort Worth in an Organized Health Care Arrangement with respect to jointly managed patients. As this is a policy of Texas Health Harris Methodist Hospital Fort Worth , by their membership on the medical staff each medical staff member therefore agrees to abide by the terms of Texas Health Harris Methodist Hospital Fort Worth '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 their participation in the OHCA. As stated in the OHCA policy, each participant is individually responsible for their own and their personnel's compliance with the Notice and its underlying policies. The Notice will not cover PHI created or received by individual physicians 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.

2.0 REQUIREMENTS FOR MEDICAL STAFF MEMBERSHIP

2.1 General

In addition to those requirements for Medical Staff Membership set forth in the Bylaws, the Medical Staff shall have the authority to include in these Rules and Regulations requirements for Medical Staff Membership. Any such additional requirements shall be cumulative and not an alternative to the requirements set forth in the Bylaws.

2.2 Continuing Medical Education

Pursuant to Sections 5.3.1(g) and 5.4(n) of the Medical Staff Bylaws, the Continuing Medical Education requirement for obtaining and maintaining Medical Staff Membership at this time is for all Members of the Staff regardless of specialty the number of hours required by the Texas Medical Board to maintain licensure. For the purpose of evaluating continuing competence, each Member shall be asked to report Continuing Medical Education obtained during the preceding two (2) years at each reappointment.

2.3 Board Certification

All Members whose initial appointment to the Medical Staff is on or after January 1, 2011, are required to be board certified in their primary specialty of practice or be in active pursuit of board certification. A Member in active pursuit of board certification must become board certified within five (5) years of initial appointment to the Medical Staff.

Until December 31, 2015, ER physicians seeking appointment to the medical staff for the primary specialty practice of Emergency Medicine, may comply with the Board Certification requirements under subsection (5.3.2) by being Board Certified in Internal Medicine, Family Practice, or Surgery; having a minimum of 10,000 hours and five (5) years of continuous Emergency Department experience; and having ACLS, ATLS and PALS certification. All applicants are subject to approval by administration as identified in their exclusive contract.

3.0 PROCTORING

3.1 General

Proctoring may be imposed for monitoring purposes only, and only by the Credentials Committee. It does not constitute a professional review action, and does not entitle the member to a hearing. The appropriate Division(s) should draft the specific proctoring procedures applicable to the intended purpose.

3.2 Requirement of Proctoring

The Credentials Committee, in its sole discretion, or upon recommendation of the Division's Quality Review Officer/Committee, may require proctoring under the following circumstances:

1) to resolve questions of clinical competence in the exercise of privileges previously granted to a member of the medical staff; or
2) to determine clinical competency in the exercise of privileges newly granted; or
3) to determine clinical competence to exercise privileges for which the hospital has decided to accept applications.

3.3 Proctors

Proctors shall be assigned by the Credentials Committee upon the recommendation of the chiefs of the division(s) whose members seek the privileges for which proctoring has been recommended.

3.4 Limitations and Responsibilities of Proctored Staff Members

(a) It is the responsibility of the Staff Member to provide the Operating Room Staff and the Staff of any other area scheduling a procedure, with the name of the Proctor who will be observing a case. The case will not be scheduled unless the Proctor's name is provided. It is the Staff Member's responsibility to arrange for the Proctor to be available. Nursing and/or Operating Room and other Staff may, from time to time, volunteer to assist the Staff Member in notifying the Proctor of a scheduled case. This, however, does not relieve the Staff Member of the responsibility for making such arrangements.

(b) Failure to obtain a case Proctor before admission in all cases of planned admissions and, in unplanned admissions no more than twenty-four (24) hours after admission, may be grounds for suspension of requested privileges.

(c) Within two (2) business days after each proctored case, the Staff Member shall notify the Medical Staff Office of the following:

(i) name of the patient;
(ii) dates of admission and discharge;
(iii) medical record number;
(iv) diagnosis; and
(v) name of the Proctor observing the case

(d) A form on which to keep a record of all cases shall be provided to the medical staff member by the Medical Staff Office.

(e) The Staff Member shall not attempt to use the Case Proctor as a consultant or assistant on any case the Proctor is observing. If the Staff Member needs a consultation, advice or assistance, it should be sought from a Member of the Medical Staff who is not the Case Proctor on the case in question.

(f) If a Proctor is contacted and unreasonably or repeatedly refuses to observe a case, the Staff Member shall immediately notify the Medical Staff Office, who shall refer the matter to the Credentials Committee for action.

(g) Only when the Division's Quality Review Officer/Committee recommends, and the Credentials Committee concurs and notifies the Staff Member, shall the proctoring period be considered complete. However, the Staff Member shall not be required to have the cases proctored while awaiting notification of completion, once the minimum requirements have been fulfilled and/or any additional requirements previously imposed.

(h) Cases proctored at another facility may be accepted if proctored by a THFW Medical Staff member in good standing or a nationally recognized expert.

(i) If a Member does not, during the period of proctoring and any extensions thereof, perform the required number of proctored cases, the privileges for which the Member was being proctored shall automatically terminate.

3.5 Limitations and Responsibilities of Case Proctors

(a) The Case Proctor must hold like privileges as the procedure being proctored but is an observer only. The Case Proctor is not present to consult, advise, or assist in the care of the patient and must remain in the room during the critical components of the procedure. If the Member needs a consultation, advice or assistance, it shall be sought from a member of the Medical Staff who is not the Case Proctor on the case in question.

(b) The Case Proctor shall not establish a physician-patient relationship with the patient of a Staff Member by virtue of the role as Case Proctor. The Case Proctor shall not speak to, examine, or charge the patient of any proctored physician. A Case Proctor shall not intervene in any surgical procedure while serving in that role.

(c) In the event that a Case Proctor exceeds the scope of the proctoring program as described in this Section 3, the Case Proctor shall be solely responsible for their own acts and may be exposed to increased risk of liability. The Hospital shall not be responsible for any claims, losses, damages or liability resulting from a Proctor exceeding the scope of the proctoring program.

(d) Each Case Proctor shall complete a report to be reviewed by the Division's Quality Review Officer/Committee containing the evaluation of the competency of the Staff Member. All Proctor's Reports that reflect problems in case handling or judgement will be promptly referred to the Division's Quality Review Officer/Committee for review.

(e) If at any time, the Case Proctor feels that the care being rendered is substandard or inadequate, the Medical Staff Member must obtain a consultation and shall immediately notify the Chief Proctor and the Division Chief of the problem.

3.6 Emergencies

The following rules shall apply to the proctoring of emergency cases:

(a) In the event that a Case Proctor cannot be present for an emergency procedure on short notice, the Staff Member shall document in writing that the Case Proctor was called and deliver the written explanation to the Medical Staff Office by the next business day. It is inappropriate to make any notation on the patient's chart concerning the call to the Case Proctor.

(b) In the event that taking the time to call the Proctor would endanger the patient and no nursing or administrative staff is available to make the call on behalf of the Staff Member, calling may be excused. A written report of the circumstances shall be submitted to the Medical Staff Office by the next business day.

(c) The Case Proctor shall review the record of emergency cases within twenty-four (24) hours of admission and shall document on the Proctor's Report Form the date and time the case was reviewed.

(d) All reports of such Emergency Cases shall be promptly referred to the Division's Quality Review Officer/Committee, if appropriate.

4.0 MEDICAL RECORDS

4.1 Practitioner's Responsibility

Attending Practitioners shall be responsible for the preparation of a complete, accurate, and legible medical record for each patient. An adequate admission note shall be written upon admission.

Consultants, surgeons, anesthesiologists, and other practitioners who participate directly in the patient's care are responsible for their parts of the medical record. The medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress, and response to medications and services. In the case of written entries that are to be scanned into the record, the entry must be legible and conform to all rules herein.

4.2 Approved Entries and Forms

Entries in the medical record should be documented in the electronic health record (EHR). Practitioners may use customized templates to facilitate documentation in the EHR. No entry shall be made in the medical record by any person unless they are authorized by the Medical Records Committee and Medical Board. Entries shall be made as soon as possible by the person(s) having knowledge of the acts, event, or condition. Paper forms used in the medical record must be approved by the Forms Committee as authorized by the Medical Records Committee.

4.3 Admission History and Physical

A clinically relevant admission history and physical examination shall be written, dictated or created within twenty-four (24) hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia. The history and physical cannot be completed more than thirty (30) days before admission or registration.

When the history and physical is dictated or written before admission or registration, an update note is required within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. Any changes in the patient's condition must be documented in the update note. Otherwise, the credentialed Practitioner shall document that the history and physical was reviewed, the patient was examined, and "no change" has occurred in the patient's condition since the history and physical was completed.

An interval history and physical is acceptable with an update note if a patient is readmitted within 30 days with the same or related problem. Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services, the Practitioner shall document the history and physical was reviewed, the patient was examined, and "no

change" has occurred in the patient's condition since the history and physical was completed.

History and physicals must be recorded and entered in the medical record before any surgery or procedure requiring anesthesia is performed, unless the surgeon documents in the medical record that any delay to record the history and physical would be a hazard to the patient.

4.3.1 Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeons who have been determined by the Medical Staff to be competent to perform a clinically relevant history and physical examination may do so. If any medical problem or condition is identified or develops subsequently during the hospitalization, a consultation must be obtained promptly with an appropriate Medical Staff Member, who will assume responsibility for the patient's medical care.

4.3.2 Dentists and Podiatrists

Dentists and podiatrists may co-admit patients only if a physician Member conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry or podiatry) and assumes responsibility for the medical care of the patient. It shall be the responsibility of the podiatrist or dentist to obtain and document in the record, at the time of admission, the services of a physician to attend to the general medical condition of the patient.

4.3.3. Content of History and Physical

The history and physical must meet Hospital guidelines as to content and timeliness and shall contain at least the following relevant information regardless of format, e.g. recorded in a transcribed report, entered in the EHR, or doctor's office record:

Date of assessment
Chief complaint
Details of present illness
Current medications and allergies
Past medical history including previous surgery
Past social history
Family history
Review of systems
Physical examination
Vital signs
Diagnosis/clinical impression/conclusions
Plan of treatment/course of actions

4.3.4 Outpatients and Observation Patients

An abbreviated history and physical shall be documented for outpatient and observation patients. The history and physical must be documented and entered in the medical record within 24 hours after admission or registration for patients admitted for observation but prior to an invasive procedure requiring anesthesia.

4.4 Reports Prior to Surgery or Invasive Procedure

The patient's medical history and physical examination and the results of any indicated diagnostic tests are recorded before the operative or other high-risk procedures are performed. When the history and physical examination and pre-anesthesia evaluation are not completed and on the medical record before an operation, or any other scheduled procedure, the procedure shall not be allowed to proceed until such records are complete except in the case of an emergency.
In an emergency, when there is no time to document the clinically relevant history and physical examination, if time permits, the primary surgeon shall document a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis before surgery in the EHR.

4.5 Progress Notes

Pertinent progress notes shall be documented in the EHR at the time of observation. These shall be sufficient to permit continuity of care and transferability of the patient. Wherever 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 treatment. Progress notes shall be documented at least daily.

4.6 Operative Reports

Each primary surgeon shall dictate or create a complete operative or other high-risk procedure report for each inpatient and outpatient before the patient is transferred to the next level of care. The report shall include the name of the primary surgeon and assistants, procedures performed and description/technique for each procedure, findings, estimated blood loss, specimens removed and post-operative diagnosis. When the operative report is dictated a post-operative progress note must be documented in the EHR before the patient is transferred to the next level of care. This progress note includes name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed; description of each procedure finding; estimated blood loss; specimens removed. If the complete operative report is created into the EHR at or before transfer to the next level of care, a post-op progress note is not required. When the Practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be created or dictated in the new unit or area of care.

Surgeons, surgical residents and physician proceduralists, i.e. endoscopists, pulmonologists, interventional radiologists, cardiologists, etc., and all other specialists who perform operations, high-risk procedures, and/or the administration of moderate or deep sedation or anesthesia shall dictate a complete operative or procedure narrative for each patient event within 24 hours of occurrence. This is the responsibility of the surgeon, surgical resident, or physician proceduralists, and **may not** be relegated to any other mid-level providers, i.e. physician assistants or nurse practitioners. This narrative report will comply with The Joint Commission and CMS standards and include all essential elements as required, including:

1. the name of the primary surgeon and assistants,
2. the name of the procedure (s) performed
3. description/technique of the procedure (s),
4. findings of the procedure (s)
5. any estimated blood loss
6. any specimen (s) removed
7. the postoperative diagnosis

Immediate Post-Operative and Post Procedure

Surgeons, surgical residents, and physician proceduralists shall complete an immediate post-operative or post procedural immediate note within the electronic health record before the patient is transferred to the next level of care. This immediate note may also be created by a physician assistant or nurse practitioner yet must be co-signed by the surgeon or proceduralist of record within 24 hours. The medical record note shall contain all essential elements as required, including:

1. Surgeon
2. Assistants
3. Procedures performed
4. Findings describing each procedure
5. Estimated Blood Loss – a specific estimation of lost blood in milliliters
6. Specimens – specific entry required; none or N/A required
7. Post Op Diagnosis

Exceptions exist if the complete operative report is created in the electronic health record at or before transfer to the next level of care. With a completed full narrative, a post-operative or post procedural immediate note is not required. When the surgeon, surgical resident, or physician proceduralist performing the operation or high-risk procedure accompanies the patient from the operating or procedure room to the next level of care, the narrative may be created or dictated at that time; however, this document must be immediately submitted into the electronic health record by either a prepopulated operative or procedure narrative customized to the patient, or by voice activated dictation. Both will provide this necessary immediate electronic hospital record entry.

4.7 Anesthesia Report

The anesthesia report shall include written documentation of at least the following:

(a) The pre-anesthesia evaluation of the patient performed by the anesthesiologist or nurse anesthetist, with appropriate documentation, including evaluation of the patient's previous drug history and anesthesia experience as well as any potential anesthesia problems. Except in urgent/emergent cases as described in Section 4.4 above, this evaluation shall be performed prior to the patient's transfer to the operating area and before preoperative medication has been administered. A pre-

anesthesia evaluation completed within 30 days can be updated. The updated pre-anesthesia assessment must be completed within 48-hours prior to surgery. If this evaluation is done by a nurse anesthetist, the documentation shall be reviewed and countersigned by the anesthesiologist responsible for the case prior to induction. See also Section 8.5 below.

(b) Documentation of the reevaluation of the patient immediately before moderate or deep sedation and before anesthesia induction.

(c) Documentation that the site, procedure, and patient are accurately identified and clearly communicated, using active communication techniques, during a final verification process such as a time-out before the start of any surgical or invasive procedure.

(d) A record of all events taking place during induction of, maintenance of and emergence from moderate or deep sedation or anesthesia, including dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions.

(e) Post-anesthetic note(s) after the patient recovers from moderate or deep sedation or anesthesia, including at least one (1) note describing the presence or absence of anesthesia-related complications.

4.8 Consultations

Consultations shall reflect a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The consultation report shall be authenticated and made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations.

Consultations are requested based on the clinical needs of the patient. Consultations should be seen within 24 hours of the requests, or sooner, based on the clinical situation.

Consultants are, as a routine, expected to see and examine the patient, and record their findings in the electronic medical record. A consultation note shall be written immediately and contain at a minimum, pertinent information for anyone required to attend the patient. A full report shall be completed within 24 hours after seeing the patient.

4.9 Obstetrical Records

The obstetrical record shall include a complete prenatal record with update note within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. Any changes in the patient’s condition must be documented by the practitioner in the update note and placed in the patient’s medical record within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. The Practitioner shall document the history and physical was

reviewed, the patient was examined and "no change" has occurred in the patient's condition since the history and physical was completed. The prenatal record shall be a durable, legible copy (carbon copies are unacceptable but photocopies are acceptable) of the attending Practitioner's office record, transferred to the Hospital before admission in a form approved by the Medical Records Committee. The history and physical must be completed within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia for women who have not receive prenatal care before the onset of labor.

4.10 Physician's (Practitioner's) Directions

The following rules shall apply to orders given by Medical Staff Members:

(a) For the purposes of this Section 4.10, "Responsible Practitioner" shall include the Attending Practitioner and any Medical Staff Member covering the practice of the Attending Practitioner.

(b) A Practitioner's orders when applicable to a given patient, shall be documented using Computerized Physician Order Entry (CPOE) and will be dated, timed and signed by the Responsible Practitioner.

(c) Only Members of the Medical Staff may issue orders for treatment except as initiated by approved protocols. All orders for treatment shall be documented using CPOE except for specific instances approved by the Medical Board. All orders dictated over the telephone shall be considered to be a written order if transmitted by the Practitioner or an employee as authorized by the Practitioner, to an employee described in Hospital Policy Outpatient Diagnostic Orders, and signed by the Responsible Practitioner. All verbal and telephone orders shall be dated, timed and signed by the person receiving the order, with the name of the Practitioner dictating the order.

(d) Telephone or verbal orders shall be documented in the EHR and require a verification "read back" of the complete order by the person receiving the order.

The Responsible Practitioner must countersign, date, and time telephone or verbal orders by the following day for:

1. Seclusion and/or restraints
2. Initial Total Parenteral Nutrition (TPN)
3. Resuscitation Status Orders (Exception: A countersignature by the attending physician is not required when the resuscitation status order is an admitting order for full resuscitation efforts because it is the usual expectation that any patient who sustains an unexpected cardiac arrest will be resuscitated.)

Failure to do so shall be brought to the attention of the Practitioner's Division Quality Review Officer/Committee for appropriate action.

All other verbal orders shall be signed, dated, and timed within 48 hours. Failure to do so shall be brought to the attention of the Practitioner's Division Quality Review Officer/Committee for appropriate action.
No telephone or verbal orders for chemotherapy will be accepted.

(e) A Member of the Medical Staff utilizing an authorized representative to transmit orders on a patient to the Hospital shall be responsible for identifying the representative to the Hospital. Authorized representatives are responsible for identifying themselves when documenting orders using CPOE.

(f) Previous orders are canceled when the patient goes to surgery. EXCEPTION: At the patient's request and with discussion between the patient and the attending physician/surgeon, the patient may have a DNR honored during surgery, anesthesia and invasive procedures (THFW Policy for Administering, Withholding or Withdrawing Life-Sustaining Treatment for Patients with Directives Executed or Issued On or After September 1, 1999). If the patient desires to suspend/cancel the DNR during surgery, anesthesia, and invasive procedures, then the DNR must be re-evaluated and rewritten after surgery, anesthesia, and invasive procedures by attending physician or surgeon.

4.11 Principal Diagnosis

The principal diagnosis is the condition established after study to be chiefly responsible for the admission or treatment of the patient. This diagnosis shall be recorded in full without the use of symbols, code numbers or abbreviations.

4.12 Discharge Summary

A discharge summary shall be created, written or dictated for all patients hospitalized over forty-eight (48) hours, including normal obstetrical deliveries and normal newborn infants. A short stay summary is sufficient for patients hospitalized less than forty-eight (48) hours. A concise discharge summary providing information to other caregivers and facilitating continuity of care includes the reason for hospitalization, significant findings, procedures performed and care, treatment, and services provided, the patient's condition at discharge and information to the patient and family as appropriate, provisions for follow-up care, final diagnosis, and disposition.

4.13 Orders Sets

The Practitioner shall review and revise, if necessary, customized order sets at a minimum of every twelve (12) months.

4.14 Abbreviations, Acronyms, and Symbols

Only abbreviations, acronyms, and symbols listed in Stedman's Abbreviations, Acronyms, and Symbols or abbreviations, acronyms, and symbols that have been widely published in medical literature, have been approved by the Medical Board for

use when documenting in the medical record. Any abbreviation, acronym or symbol that is widely published in the medical literature, but not yet in Stedman's, must be spelled out the first time it is used in any document. A standardized list of abbreviations, acronyms and symbols that are not to be used when documenting in the medical record has been approved by the Medical Board. The DO NOT USE Abbreviation list is readily available to all Practitioners and maintained by the Health Information Services department.

4.15 Inappropriate Entries

The medical record should only contain documentation that pertains to the direct care of the patient. Charting should be free from emotional feelings and statements that blame, accuse, or compromise other caregivers, the patient, or the family. The record should not be used to voice complaints about the hospital, certain hospital departments, conflicts between disciplines, staffing issues, vendor issues, etc.

All inappropriate entries shall be referred to the Practitioner's Division Quality Review Officer/Committee. Initial counseling may be done verbally by the Division Chief or Vice Chief. All subsequent counseling regarding inappropriate entries shall be documented in writing. A Practitioner who continues to make inappropriate entries after having been counseled in writing by the Division Quality Review Officer/Committee may be subject to a Professional Review Action in accordance with Section 11 of the Medical Staff Bylaws.

4.16 Authentication and Corrections

All entries in the patient's medical record shall be dated, timed, and authenticated by the appropriate Practitioner. Electronic signatures are recognized as an appropriate form of authentication.

When the Practitioner authenticates an entry in the medical record, the Practitioner certifies that the entry is accurate. Any change or addition in a medical record shall be clearly marked as a change or addition, signed, dated and timed by the Practitioner.

4.17 Consent Forms

Every patient treated shall sign a general consent form (Universal Consent for Treatment) except in the case of life, limb, or organ threatening emergencies. After an emergency situation has ceased to exist, the patient or the legal representative shall be asked to document consent on such form. In addition, all specific consents appropriate to the proposed treatment or procedure shall be documented prior to the treatment. Informed consent shall be obtained in accordance with Texas law and Hospital policy and documented appropriately only on forms approved by the Medical Records Committee and the Medical Board. Before obtaining informed consent, potential benefits, risks or side effects including potential problems related to recuperation, and reasonable alternatives to the proposed care, treatment, and service are discussed with the patient and/or family.

4.18 Medical Record Completion and Enforcement Procedure

History and physicals or operative reports shall be considered delinquent if not completed in the required timeframes as noted in Sections 4.3, 4.6 and 4.9 of Medical Staff Rules and Regulations.

The medical records of discharged patients shall be completed 14 days following discharge. Each Member of the Medical Staff is expected to comply with the policy, "Record Completion Incentive Program, Policy and Procedures." Failure to comply may constitute grounds for Automatic Relinquishment of Privileges or Automatic Resignation from staff in accordance with the Medical Staff Bylaws.

4.19 Filing Incomplete Records

A medical record shall not be permanently filed until it is completed by all responsible Practitioners or until it is ordered filed "incomplete" by the Medical Records Committee.

4.20 Release of Information

The written authorization of the patient or patient’s legal representative is required for access or release of protected health information unless otherwise authorized by law. Individuals about whom personally identifiable health data or information may be maintained or collected are made aware of what uses, and disclosures of the information will be made. Protected health information is used for the purposes identified or as required by law and not further disclosed without patient authorization.

4.21 Release of Original Records

Protected Health Information (PHI) is the property of Harris Methodist Fort Worth Hospital, and the confidentiality of this information is the right of the patient. PHI and original medical records shall not be removed from the Hospital premises except by court order, subpoena, statute, or hospital policy. Removal of a medical record from the Hospital by a Practitioner is grounds for a Professional Review Action including suspension and/or termination of membership.

4.22 Practitioner's Access to Charts

In case of readmission of a patient, all previous medical records shall be available for use by Practitioners treating the patient.

Access to medical records of patients shall be afforded to Members of the Medical Staff for quality review, utilization review, peer review and bona fide study and research projects approved by the Texas Health Resources Institutional Review Board. Review of patient records for quality and appropriateness of care is confidential and privileged under Texas law. The Medical Staff Bylaws set forth the Committees' duties in regard to these matters. These matters may not be discussed outside the Committee process. Research and study projects must provide safeguards for preserving the confidentiality

of personal information concerning the individual patients. Subject to the approval of the Chief of Staff and the Administration, and when permitted under the applicable law, a former Member of the Medical Staff may be permitted access to information from the medical records of the patients covering all periods during which the former Member attended such patients in the Hospital.

4.23 Transfer Documents (From Texas Health Harris Methodist Fort Worth Acute Care to Another Acute Care Facility):

Consent to Transfer - The physician must assess and document the patient's condition to include the risks and benefits of the proposed transfer and to attest that the benefits outweigh the risks of transfer.

Memorandum of Transfer - The physician shall confirm acceptance by a physician at the receiving facility and document date and time of confirmation.

Physician Direction for Transfer - The order shall be documented using CPOE and shall include the order to transfer, name of the facility, and the name of the accepting physician.

Each document shall be authenticated at the time of transfer and in the event that the physician is not physically present at the time of transfer, must countersign the verbal information written by the nurse within the timeframes established by the applicable transfer policies and those outlined in the Medical Staff Rules and Regulations.

5.0 ADMISSION OF PATIENTS

5.1 Who May Admit Patients

A patient may be admitted to the Hospital only by a Member of the Active or Courtesy Medical Staff who is a member of a Division other than Pathology and has admitting privileges. Members of the Emergency Medicine Division may admit inpatients on behalf of and at the request of the attending physician and write the initial orders in conjunction with the attending physician when necessary and may also admit patients to an observation unit(s) in or contiguous with the Emergency Department. Nothing herein shall prohibit members of the Division of Pathology from holding and exercising clinical privileges to perform outpatient testing.

Dentists and podiatrists may co-admit patients in accordance with Section 4.3 of the Rules & Regulations.

5.2 Criteria for Admission

Patients being admitted to inpatient, outpatient, or observation status are expected to meet Interqual or Centers for Medicare and Medicaid Services (CMS) criteria for admission and continued hospitalization.

Members of the Medical Staff are expected to work closely and cooperatively with the Hospital's Medical Management Department in making the determination regarding inpatient or observation status, providing expanded clinical documentation when requested.

Ultimately, however, these decisions rest with the attending physician, and must be based on the immediate clinical needs of the patient.

5.3 Admitting Diagnosis Required

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been recorded in the patient's medical record.

5.4 Potentially Harmful Patients

Texas Health Harris Methodist Hospital Fort Worth is neither a psychiatric nor an addiction treatment facility, therefore, for protection of other patients, the Medical Staff, the nursing staff and the Hospital, any patient known to be or suspected of being potentially capable or inclined to inflict harm on self or others should not be admitted to the Hospital but be provided with an appropriate medical screening examination, stabilization, and transfer within the hospital's "Emergency Medical Screening and Patient Transfer" policy.

If stabilization of the medical condition necessitates admission as an inpatient, the patient should be admitted to the nursing unit appropriate to provide the intensity of service and level of care indicated. The admitting physician shall arrange for psychiatric consultation and referral when clinically indicated, but promptly after admission and stabilization. To promote the safety of the patient, medical staff, nursing staff, and other patients and visitors, the attending practitioner should order suicide precautions based on the assessed potential for self harm or harm to others as described in the hospital's policy on "Care of the Patient at Risk for Suicide".

The Attending Practitioner shall give all information as may be advisable to protect the patient from self harm and to protect others whenever the patient might be a source of danger. Such information shall be clearly documented in the patient's medical record and shall be communicated verbally to the charge nurse or other appropriate nursing personnel when there is a change in the patient's condition that make a change in the patient's care or monitoring advisable. Appropriate written orders shall be given for the care of such patients.

The hospital's social service staff and Psychiatric Liaison Service are available to assist the physician with identifying resources for specialty or continuing care.

5.5 Admissions to Intensive Care Units

(a) Patients to be admitted to an Intensive Care Unit shall be seen by their attending physician or consulting intensivist within two hours of notification or sooner if clinically necessary.

(b) All admissions of pregnant and postpartum patients (up to 6 weeks postpartum) to any Intensive Care Unit require consultation with a maternal-fetal medicine physician (MFM) who is an Active or Provisional Active member of the Medical Staff. The MFM shall be consulted and notified by the attending physician at the time of admission.

(c) If any question arises as to the validity of admission to or discharge from an Intensive Care Unit, that decision is to be made through consultation with the Chairman of the Specialty Care Committee.

5.6 Admissions to Medical Intensive Care Unit

(a) All admissions to the Medical Intensive Care Unit, including those occasioned by lack of bed availability in the cardiovascular, surgical/trauma, or neuro ICUs (overflow admissions), require admission by a Medical ICU intensivist who is an Active or Provisional Active member of the Medical Staff.

(b) In addition, admissions to the cardiovascular, surgical/trauma, or neuro ICUs occasioned by lack of bed availability in the Medical ICU require a medical intensivist as attending.

(c) A medical ICU intensivist shall be defined as a physician who is board-certified in critical care medicine or who has completed sufficient education and training to sit for the critical care board examination and has not exhausted the time specified by the applicable Board to take the examination.

(d) Notwithstanding the above, the requirements described in this Rule 5.6(c) shall not apply to those physicians who completed a pulmonary fellowship, or equivalent training, prior to 1987 and have devoted a substantial percentage of their practice to critical care medicine.

(e) As an exception, in the Medical ICU, transplant surgeons may remain as attending physicians.

(f) None of this language precludes participation of appropriate specialists in the care of patients as deemed necessary.

5.7 Admissions to Neuro Intensive Care Unit

(a) All admissions to the Neuro Intensive Care Unit requires admission by the neuro intensivist who is an active or provisional active member of the medical staff.

(b) On the occasions of lack of bed availability in the cardiovascular, surgical/trauma, or medical ICUs, for overflow admissions that require admission to the Neuro ICU for critical care, the attending will be the appropriate intensivist or transplant surgeon with co-management by the neuro intensivist as needed.

(c) Neuro intensivist qualifications:

i. A neuro intensivist requires board-certification or eligibility in anesthesiology, emergency medicine, internal medicine, neurology, neurosurgery or critical care medicine, and, once certification in their primary specialty has been obtained, board certification in the subspecialty of neurocritical care as defined by either the United Council for Neurologic Subspecialties (UCNS) Board or American board Of Psychiatry and Neurology must be obtained within the eligibility period defined by those organizations.

ii. After 2014, any subsequent neurocritical care certification must be accompanied by completion of an accredited UCNS neurocritical care fellowship.

(d) For all patients admitted to the neuro intensive care unit with trauma as a mechanism of injury, a neurosurgeon or trauma surgeon will be the

admitting physician with a mandatory neurocritical care physician consultation.

(e) None of this language precludes participation of appropriate specialists in the care of patients as deemed necessary.

5.8 Admissions to Progressive Care Unit

(a) Patients to be admitted to a Progressive Care Unit shall be seen by their attending physician or their designee within 6 hours.

5.9 Admissions to the Heart Center

(a) Admission of a patient to the Heart Center from the patient's home, a physician's office, the THFW ER, or a transferring facility must either be by a Cardiologist, Cardiovascular Surgeon, Vascular Surgeon, or by an Admitting Physician in consultation with a Cardiologist, Cardiovascular Surgeon, Vascular Surgeon, or Interventional Radiologist.

(b) Patients may be transferred from another THFW floor or unit by the Attending Physician if done in consultation with a Cardiologist, Cardiovascular Surgeon, Vascular Surgeon, or Interventional Radiologist.

5.10 Admissions to the Heart Center Intensive Care Unit

(a) Admission of a patient to the Heart Center ICU from the patient's home, a physician's office, the THFW ER, or a transferring facility must either be by a Medical ICU intensivist who is an Active or Provisional Active member of the Medical Staff. A Cardio Thoracic or Vascular Surgeon, may also serve as an Admitting Physician with an automatic consultation with a Medical ICU intensivist who is an Active or Provisional Active member of the Medical Staff.

5.11 Admission to the Inpatient Rehabilitation Unit

(a) Admission of a patient for inpatient rehabilitation must be by a Physical Medicine and Rehabilitation specialty physician.

(b) Patients admitted to the inpatient rehabilitation unit should be seen by the attending physician within 24 hours of admission.

5.12 Hospitalist Care of Overflow Patients in Intensive Care Unit

On the occasions of lack of bed availability in the hospital, for overflow admissions to any ICU that do not require critical care, the admitting and attending provider may be a Hospital Medicine Physician who is an active or provisional active member of the medical staff if that individual is able

to provide all necessary care and treatment for the patient within the scope of their existing privileges.

5.13 Admissions to Surgical/Trauma Intensive Care Unit

(a) All admissions to the Surgical/Trauma ICU (STICU), other than transplant patients, require admission by a surgical intensivist who is an Active or Provisional Active member of the Medical Staff, including those occasioned by lack of bed availability in the cardiovascular, medical, or neuro ICUs (overflow admissions).

(b) On the occasions of lack of bed availability in the cardiovascular ICU, medical ICU, or neuro ICU, for overflow admissions that require admission to the STICU for critical care, the attending physician may be the appropriate respective intensivist or transplant surgeon with co-management by the surgical intensivist as needed.

(c) A surgical intensivist shall be defined as a physician who is board-certified in Surgical Critical Care by an ABMS or AOA-approved Board, or one who has completed sufficient education and training to sit for the surgical critical care examination and has not exhausted the time specified by the applicable Board to take the examination.

(d) None of this language precludes participation of appropriate specialists as consultants in the care of patients as deemed necessary by the attending surgical intensivist or transplant surgeon, in collaboration with the primary surgeon.

6.0 GENERAL CONDUCT OF CARE

6.1 Practitioners' Responsibility

Members of the Medical Staff who act as the admitting, attending, or consulting physician, or as the primary surgeon are expected to provide for the patient's safety and participate in effective communication with patients, their families, staff, and other members of the medical staff involved in the patient's care. All Members of the Medical Staff are required to be familiar and remain compliant with the requirements of the Medical Staff Bylaws and Rules and Regulations.

6.2 Attending Practitioners' Responsibility

The Member of the Medical Staff who is selected or assigned to a patient and has primary responsibility for coordinating the patient's treatment and care (the "Attending Practitioner") shall be responsible for:

(a) the medical care and treatment of such patient in the Hospital;

(b) accurately and promptly completing those portions of the medical record for which the physician is responsible;

(c) any necessary special instructions; and

(d) communicating the condition of the patient to the referring Practitioner and to the family of the patient, as appropriate.

Whenever these responsibilities are transferred to another Member of the Medical Staff, a statement covering the transfer of responsibility shall be entered on the order sheet of the medical record. The transfer order is not a valid order until the accepting physician concurs through documentation on the order sheet. Physician-to-physician communication is essential to the effective transfer of a patient's care. The Practitioner who admits the patient shall be considered the primary Attending Practitioner, unless this responsibility is transferred, as indicated above.

6.3 Daily Visits

Every in-patient must be seen by a qualified member of the Medical Staff during each 24 hour interval. The attending physician has the primary responsibility of making sure that physician attendance to the patient does not lapse.

An exception to the above may be made for patients admitted to the inpatient rehabilitation unit who are required to be seen "face-to-face" by the attending physician at least three days per week throughout the patient's stay. However, no more than two days shall elapse between physician visits.

6.4 Drugs and Medication

(a) All drugs and medications administered to patients shall be those listed in the latest editions of standard reference texts. All drugs and medication shall be administered in accordance with the following:

Prescription medications shall have proof of FDA approval or shall be part of an FDA approved clinical trial, prior to being dispensed in the Hospital. The status of FDA approval for prescription drug products will be verified by the Pharmacy Department using the most recent edition of "Approved Drug Products", published by the U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drugs and Biologics.

(b) All medications and drugs shall be identified by name and dosage. If a patient is to take the same medications in the Hospital that were taken prior to admission, the Attending Practitioner shall order these medications by name and dosage. Medications brought to the Hospital by the patient for the patient's use shall be identified and also ordered by name and dosage and not by prescription number. Unidentifiable medication shall not be given.

(c) All drugs in the categories listed below, which are ordered without specific limitations as to total dosage and/or time, shall be called to the attention of the Attending Practitioner by the nursing staff upon expiration as detailed below. The attending Practitioner will reorder the drug, change the order, or cancel it. If expiration of order occurs in the middle of the night, it may be continued and called to the attention of the attending Practitioner at the next visit of the patient.

The stop order times and categories are:

Schedule II controlled substances	5 days
Ketorolac	5 days
Antibiotics, sedatives, hypnotics, tranquilizers, glucocorticoids	10 days
Anticoagulants, schedule III-V controlled substances	10 days
All other medications	30 days

(d) A nurse may administer Pitocin to a patient under the direction of the Attending Practitioner according to hospital policy. The Attending Practitioner must be readily available until any sensitivity to the drug has been ruled out, or for a reasonable length of time after intravenous administration, except when the pregnancy is non-viable. If the Attending Practitioner cannot be available, this responsibility may be delegated to another Practitioner or to an OB/GYN Resident.

6.5 Laboratory Work

(a) The Attending Practitioner or other appropriate Practitioner shall order indicated laboratory work prior to or upon admission and on an ongoing basis

during the patient's hospital stay. A written or verbal order is required for such laboratory work.

b Each newborn shall have a State Neonatal Screen prior to discharge unless dismissed from the hospital within twenty-four (24) hours of birth.

c Critical Lab Values are defined and approved by the Medical Board as those laboratory test results that generally require immediate intervention. The laboratory staff, as well as the nursing staff, share the responsibility of notifying the ordering physician when a critical value occurs. Each member of the medical staff has the responsibility to respond promptly to messages from the hospital concerning critical values. The laboratory maintains a current list of critical lab values.

6.6 Consultations

(a) The Attending Practitioner is solely responsible for requesting consultation, when indicated, and shall contact a qualified consultant, except as set forth in paragraph (c) below. An APRN or PA with appropriate privileges may request a consultation after collaboration with their supervising physician.

1) STAT consultations should be considered urgent and result in the patient being seen in an appropriate timeframe.

2) ASAP consultations should result in the patient being seen within twelve (12) hours.

3) Routine consultations should result in the patient being seen within 24 hours.

4) Upon direct communication between the ordering physician and the consultant, these interval guidelines may be modified to meet the appropriate needs of the patient. Should there be an agreed upon variance to the recommended guidelines as listed above, documentation should be entered into the electronic health record by the requesting physician.

(b) Patients admitted after a suicide attempt may be transferred to a different level of care on order of a physician, with suicide precautions continued to ensure continuity of patient safety. The admitting physician should arrange for psychiatric consultation and referral to the Psychiatric Liaison Consultation Service promptly after admission and stabilization.
No patient admitted for a suicide attempt may be discharged unless a psychiatric evaluation is performed.

(c) Consultations are REQUIRED for induced abortion after twelve (12) weeks of pregnancy (see Section 11 Abortions), and for admissions to the Medical Surgical Intensive Care Unit or the Heart Center (see Section 5.5 and 5.6)

(d) In the event an Attending Practitioner has difficulty in arranging an appropriate consultation for the patient, the Chief of the appropriate Division should be contacted by the Practitioner. The Division Chief shall arrange for an appropriate consultation. Any Member of the Medical Staff requested by the Chief of a Division to perform a consultation under these circumstances shall comply. Failure to do so may constitute grounds for Professional Review Action under Section 11 of the Medical Staff Bylaws.

(e) In order to facilitate timely care in an End of Life case, the attending physician may authorize the consulting physician to initiate the DNR process and the Withholding / Withdrawing process.

6.7 Questioning Physician's Orders of Treatment

(a) A Registered Nurse, Pharmacist, or Therapist (herein called "Healthcare Professional") shall question a physician's, dentist's or podiatrist's order when the order or treatment (or lack of order or treatment) is:

(1) contrary to customary practice;
(2) contrary to hospital policy;
(3) contrary to patient or family wishes; or
(4) believed to be unsafe.

In addition, any Healthcare Professional should feel free to seek clarification of any order which is unclear, incomplete or with which the Healthcare Professional is unfamiliar.

(b) The Healthcare Professional who is to execute the order in question shall validate concerns regarding the orders through internal sources, including supervisors, policy/procedural manuals, reference books, and clinical resource persons.

(c) If the Healthcare Professional who is to execute the order continues to be concerned, they shall contact the ordering physician, dentist or podiatrist and describe the exact nature of the concern. If the physician, dentist or podiatrist declines to change the order and the Healthcare Professional remains concerned about the patient's well being, they shall document according to hospital policy and contact the appropriate supervisor.

(d) If the supervisor also believes that sufficient grounds exist for questioning the order, they shall contact the ordering physician, dentist or podiatrist, if in the Supervisor's opinion, a meaningful discussion can be had. If in the supervisor's opinion, contact with the physician, dentist or podiatrist who wrote the order, would not be productive (when, for example, the physician has previously stated that under no circumstances will the order be changed) or when time is

of the essence and further delay is likely to result in imminent harm to the patients, the Supervisor shall contact the Chief of the appropriate Division.

If the Chief of Division cannot be reached, the following individuals should be contacted in the following order:

(1) Vice Chief of the Division
(2) Chief of Medical Staff
(3) Vice Chief of Medical Staff
(4) Secretary of Medical Staff

(e) The supervisor shall make a note in the Physician's Order of any verbal order given by the Chief of Division (or other Medical Staff officer). The Healthcare Professional shall implement or initiate the new order. The Chief of the Division (or other officer) shall countersign the order within twenty-four (24) hours. The Chief of Division (or other officer) shall inform the ordering Practitioner of changes made in the orders.

The supervisor shall make a written report of all situations in which the orders being questioned require intervention by the Chief of Division (or Medical Staff Officer) to the appropriate Division Quality Review Officer/Committee.

6.8 Obtaining and Documenting Legal Consent

It shall be the responsibility of the Attending Practitioner and/or Surgeon to obtain the informed consent to treatment of the patients in compliance with Texas Law. The nursing staff shall be available to assist such Practitioners in obtaining documentation of such consent according to the published hospital policy.

6.9 Patients Changing Practitioners

A patient has the right to choose the Practitioner; however, no patient can be treated as an inpatient or outpatient without an Attending Practitioner. Therefore, no patient can discharge the Attending Practitioner until and unless the services of another appropriate practitioner have been obtained. Nor may a Practitioner refuse to continue to render appropriate medical care to the patient until the services of another Practitioner have been obtained.

If a patient, with or without the assistance of the hospital staff, is unable to secure the services of an alternate Practitioner and refuses further care by the Attending Practitioner, the Chief of the Division shall arrange for any Member of the Active or Courtesy staff with appropriate Clinical Privileges to assume responsibility for the care of the patient.

The Practitioner will be responsible for the care of the patient until notified and released of further responsibilities. Such change of Practitioner shall automatically cancel all previous orders for treatment.

6.10 Harassment

No Member of the Medical Staff shall degrade, berate, verbally or physically abuse, sexually touch or harass any employee, visitor, patient or other Medical Staff Member. Any behavior which violates this section or creates an intimidating work environment or interferes with any employee's ability to perform their job or any retaliation for reporting behavior believed to be in violation of this section shall be referred to the Credentials Committee and/or Practitioner Health and Rehabilitation Committee for investigation and may constitute grounds for discipline under Sections 10 and or 11 of the Medical Staff Bylaws.

Complaints of behavior which violates this section which involve hospital employees shall be evaluated by the President of THFW or the designee, who will work with the Credentials Committee to achieve an appropriate and satisfactory solution.

6.11 Disclosure of Outcomes

Patients, and when appropriate, their family members should be informed about the outcomes of care, including unanticipated outcomes. Consequently, the responsible independent practitioner or the designee should explain the outcomes of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.

6.12 Coverage for Patients

Each Member, shall name one or more Members of the Active or Courtesy Staff ("Covering Practitioner(s)") with the same or similar clinical privileges to be called to attend all the patients, take the Emergency Room or Trauma Call.

Failure to arrange for coverage and/or failure on the part of the Covering Practitioner to attend the Member's patients when called may be grounds for disciplinary action and shall be referred to the appropriate Division Quality Review Officer/Committee.

In case of failure to name such Covering Practitioner, or when neither the Member nor the named Covering Practitioner, can be located, the Chief of the Division shall have the authority to call any Member of the Division Staff to render interim treatment, should the Division Chief consider such to be necessary. If the Division Chief is unavailable, the Vice Chief of the Division or the Chief or Vice Chief of Staff may act as set forth in this subsection.

6.13 Central Line Insertion Verification

a) The need for any patient to be monitored by ECG for dysrhythmias during the insertion procedure will be at the discretion of the physician inserting the catheter.

b) The central line may be used when verified by a radiologist or the inserting physician that the line appears to be in an acceptable position.

c) Placement of all central lines will be confirmed by X-ray as outlined in the "Central Line Insertion Verification Policy."

d) The central venous catheter may be used without radiologic or fluoroscopic confirmation under any circumstance where the benefits of immediate use outweigh the risks of improper placement, also outline in the "Central Line Insertion Verification Policy."

e) Catheters inserted in the OR whose placement can be verified by direct and prompt inspection via a thoracotomy may be exempt from the stipulations outlined above.

6.14 Echocardiograms

Ordering Stat Echocardiograms is restricted to Cardiologists and Cardiovascular Surgeons. The Cardiologist placing the order must either interpret the study within three (3) hours of completion or identify a colleague that has agreed to do so. If a Cardiovascular Surgeon orders a Stat Echocardiogram, they must identify a Cardiologist that agrees to read the study within three (3) hours of completion. Other physicians that want to have a Stat Echocardiogram performed and interpreted must speak directly with a Cardiologist that agrees to order and read the study within three (3) hours of completion.

7.0 EMERGENCY SERVICES

7.1 Physician Coverage and Call Lists

The Medical Staff shall establish a method of providing medical coverage in the Emergency Medicine Department, in accordance with the Hospital's basic plan for the delivery of such services.

The Emergency Medicine Department shall maintain call lists for designated specialty and sub-specialty groups. The Emergency Medicine Department shall distribute copies of the call list pursuant to the instructions of each group.

Unless a written agreement between the Hospital and a Member (or Member's Practice Group) provides otherwise, Members are permitted to schedule elective procedures, and to simultaneously take call coverage at other facilities, during times they are scheduled for Emergency Department Call at THFW. When Members schedule elective procedures or take simultaneous call at other facilities, it shall be the Member's duty to contact their Covering Practitioner(s) if they are unable to meet their call coverage responsibilities (upon receiving a call from the THFW ED requesting that Member's services).

In the event gaps are identified after preparation of a particular specialty's monthly ED Call Coverage schedule, the Emergency Medicine Department shall, where appropriate, notify the following entities of these gaps:

1) local Emergency Medical Services, and
2) the closest hospital known to have the particular specialty on staff where a gap exists.

It shall be within the hospital's sole discretion whether to contract with individual physicians or physician groups for the provision of ED call coverage services at THFW.

It is the responsibility of every Member of the Medical Staff whose name appears on the call list for the Emergency Medicine Department call group to respond to a call from the Emergency Medicine Department within 30 minutes. If such Member does not respond within 30 minutes or refuses to respond, the Director of the Emergency Medicine Department (or the designee) shall notify the Chief of the Division of which the non-responding practitioner is a Member. If the Chief cannot be contacted, the Director may contact the Vice Chief of the Division, the Secretary of the Division, or the Chief of Staff. It is the responsibility of the Division or Medical Staff Officer contacted to provide another practitioner to care for the patient.

In the event a requested specialty is determined not to be available and the patient requires immediate attention, an appropriate transfer should be initiated in accordance with hospital transfer policies and agreements.

Any failure to respond or to provide for back-up coverage as described below in Rule 7.3, may be grounds for disciplinary action and shall be referred to the appropriate Division Quality Review Officer/Committee.

7.2 Call Schedules

Every designated specialty or sub-specialty of the Medical Staff shall create and maintain a schedule by which emergency services shall be provided to patients in the Emergency Medicine Department.

7.3 Covering Practitioners

Each Member shall name one or more Members of the Active or Courtesy Staff ("Covering Practitioner(s)") with the same or similar clinical privileges to be called to attend all the Member's patients, take Emergency Department or Trauma Call whenever unable to be reached, or otherwise is unable or unwilling to respond (e.g. automobile breakdown, responding to previous call, etc.). Any Member whose name appears on the ED Call Schedule may formally arrange for another Member with the same or similar clinical privileges, who is eligible to take ED Call and has not been excluded from ED Call coverage, to take the ED Call Rotation. However, he is not formally relieved of the ED call responsibility until he communicates the name of the replacement physician to the Hospital employee who maintains the ED Call Schedule and the replacement physician confirms verbally or in writing to such employee the willingness to accept the Call Rotation. Any Member providing back-up coverage shall be responsible to attend all patients of the Member for whom he is covering. This requirement may be met with periodic notifications on file clarifying the call arrangement of physician groups.

Failure to arrange for coverage and/or failure on the part of the Covering Practitioner to attend the Member's patients when called may be grounds for disciplinary action and shall be referred to the appropriate Division Quality Review Officer/Committee.

In case of failure to name such Covering Practitioner, or when neither the Member nor the named Covering Practitioner can be located, the Chief of the Division shall have the authority to call any Member of the Division to render interim treatment, should the Division Chief consider such to be necessary. If the Division Chief is unavailable, the Vice Chief of the Division or the Chief or Vice Chief of Staff may act as set forth in this subsection.

7.4 Emergency Medicine Department Patients - Private Physicians

The Emergency Medicine Department shall make a reasonable effort through the patient and family to identify the patient's private physician.

The Emergency Medicine Department shall contact the physician of the patient's choice, if appropriate. If the patient has no preference, but has an established relationship with a primary care physician or an appropriate specialist, such physician shall be contacted by the Emergency Medicine Department and asked to attend the patient. The physician may attend the patient, recommend another physician, or ask that the Emergency Medicine Department contact a Member on call in the appropriate specialty.

7.5 Major Multiple Trauma Patients

Major multiple trauma patients are those who have experienced multiple-system trauma as defined by the American College of Surgeons. The Emergency Medicine Department shall determine which patients qualify as having multiple system trauma and shall call a trauma surgeon to care for such patients. The trauma surgeon shall assume responsibility for the patient and shall select sub-specialists to assist in the care of the patient with input from the patient's private primary care physician, if known.

7.6 Medical Records

A medical record is maintained for every patient receiving emergency services and shall be incorporated into the inpatient medical record upon admission to the hospital. Medical records of patients who have received emergency care, treatment, and services contain the following:

a) Emergency care, treatment, and services provided to the patient before arrival;

b) Times and means of arrival;

c) Documentation of pertinent history of the injury or illness, assessments, orders, test results, diagnosis or impressions;

d) Whether the patient left against medical advice;

e) The conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment and services;

f) Referrals to practitioners or providers of services outside the Hospital. A copy of the medical record is available to the practitioner or medical organization providing follow-up care, treatment, and services.

Each patient's medical record shall be signed by the Practitioner in attendance who shall be responsible for its clinical accuracy.

7.7 **Disaster Plan**

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities, in conjunction with other emergency facilities in the community. It shall be developed by the Emergency Preparedness Committee of the hospital with physician participation. The plan shall be rehearsed at least twice each year.

7.8 **Emergency Admissions**

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the life or health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

7.9 **Medical Screening Exam**

Any individual who presents to the Hospital's Emergency Medicine Department requesting an examination or treatment for a medical condition shall receive an appropriate medical screening exam to determine the existence of an emergency medical condition. The medical screening exam shall be conducted by a physician on the Medical Staff of the Hospital unless such exam is allowed to be conducted by other qualified medical personnel as provided by this Section. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the life or health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Any individual who is not a patient and presents on hospital property requesting an examination or treatment for an emergency medical condition shall also receive an appropriate medical screening exam. In both scenarios, if the individual is unable to make the request, then the request is considered to have been made if a "prudent layperson" would believe that an examination or treatment would be necessary.

For obstetrical patients only, (1) who are 20 weeks gestation or greater; and (2) who have had prenatal evaluation and ongoing care by an obstetrician who has active staff privileges at THFW, an RN in the Women's Services Department who has completed appropriate education and training through the Hospital and Unit-specific orientation (as well as supervised practice) may perform such medical

screening exams in accordance with these Rules and Regulations. The RN must communicate the findings of the assessment to the physician who will then determine the appropriate plan of care and disposition of the patient.

A medical screening exam of an obstetrical patient is required to be performed by a physician if (1) the patient is being considered for transfer to another facility; (2) the nurse, based upon the assessment findings, requests a physician to evaluate the patient during admission or prior to dismissal; or (3) if the patient requests an examination by a physician. If the patient requests an examination by a physician, the patient's physician will be notified and either the patient's physician or another physician on call or otherwise available at the Hospital must evaluate the patient. An exception to this requirement can be made for those patients who require immediate transfer and for whom the wait for physician evaluation would be detrimental to the patient. In those cases, a telephone order for the transfer must be documented in the patient's medical record along with a narrative explaining the reasons that a physician was unable to personally evaluate the patient before transfer.

8.0 DISCHARGE OF PATIENTS

8.1 Discharge Planning

In an effort to facilitate the smooth transition from inpatient to the post-hospitalization status, the medical staff authorizes the nursing staff to initiate discharge planning on the first day of the patient's stay. Anticipated needs of the patient following discharge will be discussed with the patient's physician(s). The patient's physician(s) must write the order(s) for any discharge plans prior to their implementation

8.2 Discharge by Written Order

Patients shall be discharged only on the order of the Attending Practitioner, except as described in Section 9.7 of these Rules and Regulations.

8.3 Patients Leaving AMA

Should a patient leave the Hospital against the advice of the Attending Practitioner or without proper discharge, Attending Practitioner or nurse shall document the facts surrounding the patient's departure in the medical record.

8.4 Patients Released on Pass

A Practitioner shall not release an in-patient for any period of time unless accompanied by hospital personnel.

8.5 Death of a Patient

In case of a patient's death, the nursing staff shall notify the Attending Physician. The patient shall be pronounced dead within a reasonable time by a physician or by a registered nurse pursuant to a protocol jointly developed by the Medical Staff and nursing staff and approved by the Medical Board.

In the case of a patient on artificial life support, the pronouncement of death shall only be made by the Attending Physician or another physician at the request of the Attending Physician.

In the case of a patient not on artificial life support, the pronouncement of death shall be made by the Attending Physician, another physician at the request of the Attending Physician, or a registered nurse at the request of the Attending Physician. The body shall not be released until an entry recording the death has been made and signed in the medical record.

8.6 Request for an Autopsy

It is the duty of each Attending Practitioner to secure a meaningful autopsy as defined by CAP criteria whenever possible. An autopsy may be performed only with a written consent, obtained in accordance with state laws. All autopsies shall be performed or arranged by one of the Hospital pathologists unless the death is reportable to the Medical Examiner or as requested by the family. Provisional anatomic cause of death shall be recorded on the medical record within seventy-two (72) hours; and the complete autopsy protocol should be made a part of the record as soon as available.

9.0 GENERAL RULES REGARDING SURGICAL CARE

9.1 Dental Patients

A patient admitted for dental care is a dual responsibility which involves the dentist or oral surgeon and a physician Member of the Medical Staff.

(a) Responsibilities of the dentist/oral surgeon include:

(1) Requesting an appropriate Medical Staff physician to perform a history and physical examination and prompt evaluation within twenty-four (24) hours of admission, and before any therapeutic or diagnostic intervention, to determine the risk and potential effect of any proposed oral surgical procedure on the patient. Oral surgeons who are qualified in accordance with Section 6.2.3 or 6.3.3 of the Medical Staff Bylaws may perform the History and Physical on appropriate patients.

(2) Recording a detailed dental history which justifies Hospital admission.

(3) Recording a detailed description of the examination of the oral cavity and a preoperative diagnosis.

(4) Dictating a complete operative report which describes the finding and technique. In cases of extraction of teeth, the dentist/oral surgeon shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to a Hospital pathologist for examination.

(5) Recording such progress notes as are pertinent to the oral condition.

(b) Responsibilities of the physician include:

(1) Recording medical history pertinent to the patient's general health (See Subsection (a)(1) above);

(2) Recording physical examination to determine the patient's condition prior to anesthesia and surgery (See subsection (a)(1) above); and

(3) Supervising the patient's care for any non-dental problem including medical complications.

(c) Discharge of the patient shall be on written order of the dentist or oral surgeon Member of the Medical Staff, unless the patient has had medical complications, in which event, the discharge order must be co-signed by the physician.

9.2 Podiatric Patients

A patient admitted for podiatric care is a dual responsibility which involves the podiatrist and a physician appointee to the Medical Staff.

(a) Responsibilities of the podiatrist include:

(1) Requesting an appropriate Medical Staff physician to perform a history and physical examination and prompt evaluation within twenty-four (24) hours of admission, before any therapeutic or diagnostic intervention, to determine the risk and effect of any proposed podiatric surgical procedure on the patient.

(2) Recording a detailed podiatric history which justifies Hospital admission.

(3) Recording a detailed description of the examination of the foot and a preoperative diagnosis.

(4) Dictating a complete operative report which describes the finding and technique. All tissue shall be sent to a Hospital pathologist for examination.

(5) Recording progress notes as are pertinent to the podiatric condition.

(b) Responsibilities of the physician include:

(1) Recording medical history pertinent to the patient's general health;

(2) Recording physical examination to determine the patient's condition prior to anesthesia and surgery; and

(3) Supervising the patient's care for any non-podiatric problem including medical complications.

(c) Discharge of the patient shall be on written order of the podiatrist Member of the Medical Staff, unless the patient has had medical complications, in which event, the discharge order must be co-signed by the physician.

9.3 Informed Consent

It is the responsibility of the attending surgeon to obtain a written, signed, informed surgical consent prior to every operative procedure, except in those emergency situations wherein the patient's life or limb is in serious jeopardy and consent cannot be obtained because of the condition of the patient.
(See Section 4.17 Medical Records).

9.4 The Anesthesia Record

The Anesthesiologist or nurse anesthetist shall maintain a complete anesthesia record. (See Section 4 Medical Records).

9.5 Antibiotic Timing

Any antibiotic timing order given by a practitioner that is specific for preoperative administration, will be interpreted such that the exact timing of said antibiotic infusion will occur between 0 and 60 minutes prior to incision, and will become a joint responsibility of the anesthesia staff and the operating room nurse. Appropriate and specific infusion rates apply to each antibiotic ordered. Those protocols requiring multiple, sequential antibiotics will be administered after consultation with the ordering surgeon.

9.6 Surgical Specimens

All tissue removed in surgery, except organs and tissue to be transplanted, shall be sent either to the Bone Bank or to a Hospital pathologist who shall make such examination as the pathologist may consider necessary to arrive at a diagnosis. The authenticated report shall be made a part of the patient's medical record.

Exceptions to the requirement of submitting all surgical specimens for examination may be granted only by the Medical Board and Board of Trustees. A record (list) of such exceptions shall be kept in the Pathology Department by the Chief of Pathology.

9.7 Discharge from Recovery Area

The Anesthesiologist or the Surgeon who is familiar with the patient is responsible for the decision to discharge a patient from the recovery area. When the Anesthesiologist or the Surgeon is not personally present to make the decision to discharge or does not sign the discharge order, discharge criteria which have been approved by the Medical Board shall be rigorously applied to determine the readiness of the patient for discharge, and the name of the Anesthesiologist or the Surgeon responsible for the discharge shall be recorded in the patient's medical record.

9.8 Sterilization of a Patient

Sterilization may be performed upon the request of a competent adult patient. Prior to proceeding with an operation which produces sterilization, a written signed, informed surgical consent on a special Harris Methodist Fort Worth form will be obtained from such a patient. Consent of the spouse is not required.

Surgery which incidentally produces sterilization can be performed on a minor or a person who is mentally incompetent only after a consultation has been obtained from another Member of the OB/GYN Division. A procedure which is primarily for the purpose of sterilization and is not being performed for a medical or health reason, shall not be performed on a minor or a person who is mentally incompetent, without a court order or other judicial review.

10.0 OUTPATIENT (AMBULATORY) SERVICES

10.1 Outpatient Surgery

(a) Medical Records

A medical record is maintained on every patient receiving outpatient services. The medical record contains patient-specific information, as appropriate, to the care, treatment and services provided. Minimum documentation shall include, history and physical, operative report, post-operative progress note, discharge summary, diagnostic and therapeutic orders, diagnostic and therapeutic procedures, tests and results. Documentation on an approved short stay summary form is sufficient for patients hospitalized forty-eight (48) hours or less.
Also, see Section 4.0 for general requirements for medical records.

(b) Pre-operative Evaluation and Documentation

Surgery shall be performed only after an appropriate history and physical examination and any necessary laboratory work and X-ray examinations have been completed and the pre-operative diagnosis has been recorded.

See Section 4.3 A complete history and physical performed within thirty (30) days prior to admission is acceptable with an update that includes a physical exam and the presence or absence of any changes from the original history and physical. The update must be recorded within 24 hours of admission and written or attached to the original history and physical. The original history and physical must be recorded by a member of the medical staff.
See Section 4.4 Reports Prior to Surgery
See Section 4.6 Operative Reports

(c) Discharge Procedure:

Patients receiving general moderate, or deep sedation or anesthesia shall be discharged only after discharge criteria which have been approved by the Medical Board has been met. A patient that meets such criteria may be discharged pursuant to the verbal or written order of the Surgeon or Anesthesiologist. Patients who do not meet the established discharge criteria, must be evaluated by a physician prior to discharge and the discharge order written on the chart.

10.2 Non-Surgical Outpatients

(a) Non-surgical outpatients include those patients seen in the hospital for treatments or diagnostic procedures which do not involve surgery. All orders shall be given and signed by one of the following licensed practitioners:
1) a Medical Staff Member;

2) a physician assistant or advanced practice nurse who is a member of Hospital's Allied Health Professional staff.

(b) A medical record is maintained on every patient receiving outpatient services, as appropriate, containing patient-specific information regarding the care, treatment and services provided.

(c) Handwritten orders shall be legible. Use of the Member's or Allied Health provider's ID number in addition to his/her signature should be encouraged.

(d) 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.

10.3 Outpatient Orders from Outside Practitioners

(a) Outpatient orders may be received from physicians (MD,DO), dentists (DDS or DMD), podiatrists (DPM), chiropractors and optometrists who are not Members of the Medical Staff (Outside Practitioner) and physician assistants and advanced practice registered nurses who are not authorized to act as an Allied Health Professional (Physician Extender) if the Outside Practitioner and Physician Extender giving the order: (a) is responsible for the care of the patient; (b) is acting within the scope of his/her practice under Texas law (which means he/she must have a Texas license); and (c) is not on the exclusion list of the federal or state Office of the Inspector General (which includes the Physician Extender's supervising physician) for the following outpatient services:

(1) Collection and processing of laboratory specimens
(2) Rehabilitation services such as, but not limited to, physical therapy, occupational therapy, speech language pathology, pulmonary rehab and cardiac rehab;
(3) Radiography, with and without contrast;
(4) Respiratory therapy procedures including pulmonary function testing;
(5) Neurodiagnostic testing;
(6) Wound care including hyperbaric treatment;
(7) Ostomy care;
(8) Mammography;
(9) Biopsies;
(10) Myelograms
(11) Infusion Center orders (including, but not limited to, Blood transfusions, Iron Infusions, PICC Lines)
    (i) Excluding aphresis & Chemotherapy

(b) A medical record is maintained on every patient receiving outpatient services, as appropriate, containing patient-specific information regarding the care, treatment and services provided.

(c) Handwritten orders shall be legible. Use of the Member's or Allied Health provider's ID number in addition to his/her signature should be encouraged.

(d) 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.

11.0 CONTROL OF INFECTION

11.1 Report of Infections

(a) All infections are to be duly noted in the medical record by a member of the Medical Staff.

(b) Information on state reportable infections should be transmitted to the Infection Control Practitioners for reporting to the appropriate County Health Departments. The list of reportable infections is maintained in the Infection Control office and may be found on the facility's intranet web-site "Infection Control" (http://ftwweb05/hmfw8/Infection/ICMIndex.html).

11.2 Isolation Procedures

(a) The Pharmacy and Therapeutics Committee shall approve policies and procedures for the isolation of patients admitted with infectious diseases and for those patients who develop infectious diseases subsequent to admission. This Committee shall have authority to take any appropriate remedial actions.

(b) Hospital staff will initiate isolation precautions according to hospital policies and procedures. Isolation policies and a current list of current conditions requiring isolation precautions are located in the Infection Control Manual in every department and each nursing unit, as well as on the facility's intranet web-site "Infection Control" (http://ftwweb05/hmfw8/Infection/ICMIndex.html) .

(c) The Infection Control practitioners have the authority to initiate and enforce infection control protocols/policies. This includes placing a patient into isolation when deemed necessary.

12.0 ABORTIONS

12.1 Counseling

Abortion is an operative procedure and may be performed in this Hospital only by a Practitioner authorized to admit and care for OB/GYN patients. Before scheduling, the Practitioner shall satisfy himself that the patient has had full access to relevant facts and the opportunity to weigh the issues in her particular life situation. The Practitioner shall have satisfied himself that the patient understands what abortion means, has been informed about and thought through the possibility of accepting the pregnancy as an alternative, and that she has concluded that she nevertheless wants an abortion and that she has not been coerced by her parents, husband, friends or others. The Practitioner, if he deems himself qualified and has the time to do so, may furnish this counseling himself, or he may require the patient to receive it from others. Prior to scheduling the procedure, the patient will be asked to sign a hospital statement that she has been offered or advised to seek counseling as to alternatives to abortion by her clergy-person, by a chaplain on the Pastoral Care Staff of HMFW, or by another spiritual counselor of choice. The written statement will be a part of the patient's medical record maintained by the hospital.

12.2 Consent and Consultations

The Hospital's written consent form required in advance of all abortions shall be in writing from the patient or from the parent or guardian, if the patient is an unmarried minor. Assuming that the Practitioner has concluded that the patient has had the necessary counseling, that an induced abortion is indicated, and that he is willing to perform the task, then:

(a) If the abortion is to be induced prior to the end of the first twelve (12) weeks of pregnancy, the decision of the pregnant woman's Attending Practitioner shall be sufficient; however,

(b) If the patient has completed twelve (12) weeks of pregnancy, an induced abortion may be performed only as a therapeutic abortion for the purpose of saving the life of the mother, for serious fetal and/or genetic abnormalities, or for attempting to avoid probable serious and permanent crippling of the mother or for other serious medical reasons. Prior to the abortion decision and its effectuation in this instance, consultation and agreement shall be required from at least one (1) additional Active OB/GYN staff Practitioner and, one (1) Member of the Active Staff from the specialty which encompasses that field of medicine involved with the reason for the therapeutic abortion (e.g. Neonatology, Cardiology, Internal Medicine).

12.3 Legal Requirements

All providers shall comply with state and federal legal requirements that apply to the performance of an abortion. Accordingly, an abortion may not be performed on a woman who is pregnant with a viable unborn child during the third trimester of pregnancy unless:

i. the abortion is necessary to prevent the death of the woman;

ii. the viable unborn child has a severe, irreversible brain impairment; or

iii. the woman is diagnosed with a significant likelihood of suffering imminent severe, irreversible brain damage or imminent severe, irreversible paralysis.

12.4 No Requirement to Perform Abortion

A Practitioner shall not be required to perform an induced abortion in Harris Methodist Fort Worth, and no Hospital personnel having religious or moral objection to participating in an abortion shall ever be required to participate. No individual shall be penalized or otherwise discriminated against for such refusal to participate.

13.0 INTERPRETATION PANELS

13.1 Interpretation Panels - General Provisions

13.1.1 Types of Panels

The Panels (the "Panels") at HMFW consist of the following:

(a) Electroencephalogram and Evoked Response Panel
(b) Pulmonary Function and Reconditioning Panel

Only the Medical Board, with the approval of the Board of Trustees, may create or dissolve a Panel.

13.1.2 Functions of Panels

The members of each Panel shall interpret diagnostic tests in the Panel's discipline in accordance with the schedule established by the Panel and be responsible for such other duties as the Panel may undertake.

13.1.3 Panel Membership

Each Panel shall consist of members in good standing of the Active Medical Staff who hold Clinical Privileges to perform the diagnostic services which are the responsibility of the Panel.

The criteria for Panel Membership shall be established and revised as necessary by the Panel Committee which shall be subject to the review and approval of the Medical Board.

Each Panel Committee shall review, in light of criteria for Panel Membership, the application of each member in good standing of the Active Medical Staff who submits an application for appointment or reappointment to the panel. After its review of an application, the Panel Committee shall send its findings through the Credentials Committee to the Medical Board for action on the application, and for approval by the Board of Trustees.

13.1.4 Removal of Panel Member

A member of any Panel who no longer qualifies for membership on the Panel or on the active Medical Staff shall be automatically removed from the Panel. A Panel Committee may recommend to the Medical Board through the Credentials Committee removal of any member from the Panel for failure to fulfill a rotation assignment, failure to provide appropriate documentation, substandard interpretations or for any other reason which may pose a threat to patient care or the orderly administration of the Hospital.

The Chairman of a Panel Committee may summarily suspend any member of the Panel from the rotation schedule when the Chairman believes that a failure to do so may threaten patient safety or well being. Permanent removal from a Panel in this situation requires Medical Board action. Such suspension and/or removal from a Panel without concomitant loss of delineated clinical privileges does not constitute a Professional Review Action under Section 11 of the Medical Staff Bylaws and does not entitle the Physician to a hearing.

13.1.5 Meetings of Panels and Panel Committees

Each Panel shall meet no less often than once each year to elect a Panel Committee. The Panel may meet more often as determined by each Panel. Meeting of the Panel shall be called by the Chairman of the Panel Committee.

Each Panel Committee shall meet no less often than once each year and more often if necessary to perform its duties as set out in Section 13.1.7 below.

13.1.6 Election of Panel Committees

Each year, at a time determined by the Panel, each Panel shall elect a Panel Committee from the membership of the Panel. Each Panel shall determine the size of its Committee and the qualifications for service on the Committee and how a Chairman and Vice Chairman are to be selected.

13.1.7 Duties of the Panel Committees

The duties of the Panel Committees shall include:

(a) recommending to the Credentials Committee objective criteria, including training and experience, necessary for becoming a Panel Member;

(b) establishing quality review standards for Panel Members;

(c) reviewing performance of Panel Members and making recommendations to the Medical Board through the Credentials Committee for continuance or discontinuance of each Panel Member prior to the beginning of each rotation. This review function may be performed by the Panel Committee or by a Subcommittee for Quality Review as determined by each Panel. Any quality concerns which are identified through the Quality Review process shall also be referred to the appropriate Division Quality Review Officer/ Committee.

(d) establishing an equitable schedule for each rotation, including provisions for alternate readers, if appropriate. A rotation schedule should be no less than six (6) months nor more than two (2) years; and

(e) establishing a written policy concerning the functions and duties of the Panel;

(f) other duties as delegated or requested by the Panel or the Medical Board.

13.1.8 Individual Panel Member Responsibilities

(a) In General

Each member of a Panel shall perform interpretations in accordance with guidelines established by the Panel Committee and shall serve on the Panel Committee or a QR Subcommittee, if appointed or elected . Each member shall fulfill the rotation as scheduled or make an appropriate arrangement with another Panel Member to fulfill the rotation.

(b) Scope of Each Interpretation

Each report shall include, such information as determined by the appropriate Panel.

13.2 Functions and Purposes of Panels

13.2.1 Electroencephalogram and Evoked Response Panel

(a) In General

Interpretations of Electroencephalogram and Evoked Response Panel tracings performed at Harris Methodist Fort Worth shall be done by the members of the Electroencephalogram and Evoked Response Panel.

(b) Electroencephalogram and Evoked Response Panel Responsibility

The Electroencephalogram and Evoked Response Panel shall provide qualified members to interpret Electroencephalogram and Evoked Response tracings at Harris Methodist Fort Worth.

(c) Qualifications for Membership

In order to qualify for membership on the Electroencephalogram and Evoked Response Panel, a member of the Medical Staff must meet the following criteria:

- Be a member of the Active Staff;
- Be a member in good standing;
- Be in active practice;
- Have delineated privileges to interpret Electroencephalogram and Evoked Response tracings;
- Be Board certified in Neurology or Psychiatry or

be a current panel member in good standing.
- Such other qualifications as recommended by the Electroencephalogram Panel and approved by the Medical Board.

13.2.2 Pulmonary Function and Reconditioning Panel

(a) In General

All interpretations of Pulmonary Function and Reconditioning tests performed at Harris Methodist Fort Worth shall be done by the members of the Pulmonary Function and Reconditioning Panel.

(b) Pulmonary Function and Reconditioning Panel Responsibility

The Pulmonary Function and Reconditioning Panel shall provide qualified members to interpret all Pulmonary Function and Reconditioning tests at Harris Methodist Fort Worth.

(c) Qualifications for Membership

In order to qualify for membership on the Pulmonary Function and Reconditioning Panel, a member of the Medical Staff must meet the following criteria:
- Be a member of the Active Staff;
- Be a member in good standing;
- Be in active practice;
- Have delineated privileges to interpret Pulmonary Function and Reconditioning tests;
- Be Board-certified in Pulmonary Disease
- Such other qualifications as recommended by the Pulmonary Function and Reconditioning Panel and approved by the Medical Board.

14.0 ALLIED HEALTH PROFESSIONALS

14.1 Allied Health Professionals Generally

Allied Health Professionals governed by these Rules and Regulations shall include the following groups not employed by the hospital:

(a) Healthcare/Surgical/Pathology Assistants
(b) Allied Mental Health Professionals;
(c) Psychologists and Doctoral Scientists
(d) Advanced Practice Nurses to include but not limited to: CRNA's, Nurse midwives, Neonatal Nurse Practitioners
(e) Perfusionists
(f) Orthotists/Prosthetists
(g) Medical Physicists
(h) Physician Assistants

14.2 Definition

(a) Healthcare Assistants and Surgical Assistants and Pathology Assistants

A Healthcare Assistant, Surgical Assistant, or Pathology Assistant under this Section is a skilled individual qualified by academic and/or practical training to provide patient services under the supervision and direction of a Member of the Medical Staff, whose qualifications are those of being an RN, an LVN, a graduate of an approved course in professional technician training, or a person with satisfactory previous experience, and whose qualifications are acceptable to the Medical Staff of Texas Health Harris Methodist Hospital Fort Worth. Uncertified healthcare assistants will be limited to practice within their designated specialty (e.g., Dental).

(b) Allied Mental Health Professionals

Allied Mental Health Professionals shall have appropriate training and/or experience to be certified or licensed in the State of Texas under the applicable State Practice Act(s) and they shall hold current licensure or certification. Examples of Allied Mental Health Professionals include: Licensed Chemical Dependency Counselors, Licensed Professional Counselors, Certified Social Workers, RN Advanced Clinical Practitioner in Mental Health.

(c) Psychologists and Doctoral Scientists

All psychologist and doctoral scientists shall function strictly within the limits of the license issued by the State of Texas, if any, and in accordance

with orders or requests for consultation, including testing, from a Member of the Medical Staff.

Psychologists are required to have a Ph.D. in clinical psychology from an American Psychological Association (APA) approved school, an Internship in clinical psychology at an APA approved institution and licensure by the Texas State Board of Psychological Examiners as a health service provider.

(d) Advanced Practice Nurses

Advanced Practice Nurses (APN) are registered nurses, currently licensed in the State of Texas, who are prepared for advanced nursing practice by virtue of knowledge and skills obtained through a post-basic or advanced educational program of study acceptable to the Board of Nurse Examiners for the State of Texas. Graduates of a School of Nurse Anesthesia are eligible to submit an application to be credentialed to provide anesthesia services prior to taking the certification exam. Failure to pass the qualifying examination on the second attempt shall automatically terminate the GRNA's privileges.

(e) Perfusionists

A perfusionist is a skilled person qualified by academic and clinical education who operates extracorporeal circulation equipment during any medical situation where it is necessary to support or temporarily replace the patient's cardiopulmonary-circulatory function.

(f) Orthotist/Prosthetist

The Orthotist and Prosthetist address neuromuscular and structural skeletal problems in the human body with a treatment process that includes evaluation and transfer of forces using orthoses and protheses to achieve optimum function, prevent further disability and provide cosmesis. The orthotist designs and fits devices, known as orthoses, to provide care to patients who have disabling conditions of the limbs and spine. The prosthetist designs and fits devices, known as prostheses, for patients who have partial or total absence of a limb.

(g) Medical Physicist

A Medical Physicist is required to have a Bachelor of Science degree or Bachelor of Applied Science degree with a major in Physics. A Physicist develops and operates medical radiation therapy equipment, calculates and

controls the amount of radiation and ensures that medical radiation is utilized effectively and appropriately.

(h) Physician Assistant

A Physician Assistants must be currently licensed in the State of Texas and academically and clinically prepared to provide healthcare services under the direction and responsible supervision of a Member of the Medical Staff approved as a supervisor by the Texas State Board of Medical Examiners. Additionally, the Physician Assistant must be certified by the National Commission on Certification of Physician's Assistants (NCCAP), or qualified for examination and actively pursue and successfully attain certification (NCCAP) within 2 years of privileges being granted.

14.3 Qualifications for Privileges

Only an Allied Health Professional who can demonstrate the following shall be eligible to apply for or maintain clinical privileges as an Allied Health Professional.

(a) current Texas licensure or certification, if required or available,

(i) evidence of current licensure/certification must be provided no later than the expiration date of the license.

(ii) failure to provide such evidence shall result in automatic suspension of privileges upon the expiration date of the license.

(iii) failure to provide evidence of licensure within sixty (60) days of the expiration date of the license shall result in automatic termination of privileges.

(b) professional liability insurance coverage as required by the Board of Trustees,

(i) evidence of professional liability insurance coverage must be provided no later than the expiration date of the policy.

(ii) failure to provide such evidence shall result in automatic suspension of privileges upon the expiration date of the insurance.

(iii) failure to provide evidence of insurance within sixty (60) days of the expiration date of the policy shall result in automatic termination of privileges.

(iv) any Allied Health Professional who cancels, reduces, or loses their insurance shall notify the Medical Staff office no later than five (5) days after receipt of notice of such cancellation, loss or reduction; failure to report such loss shall result in automatic termination of privileges.

(c) education and training as described in this Section 14.0, and any further qualifications as required for specific privileges requested,

(d) current competence in the areas in which privileges are requested,

(e) good professional reputation and conduct,

(f) ability to work effectively with others,

(g) satisfactory physical and mental health,

(i) All Allied Health Professionals shall provide evidence satisfactory to the Credentials Committee that they are physically and mentally qualified to perform their professional duties.

(ii) If reason exists to question the physical and/or mental health, including questions surrounding substance abuse or possible impairment, of the Allied Health Professional, the Allied Health Professional shall, upon request, submit to an evaluation of their physical and/or mental health, including testing for possible substance abuse.

(iii) Such evaluation may be requested by the Credentials Committee, and shall be performed by a physician selected by the Credentials Committee.

(iv) Such evaluation shall be a prerequisite to further considerations of the Allied Health Professional's application for initial or renewal of privileges, or to the continued exercise of previously granted privileges.

(v) refusal to promptly submit to such evaluation is sufficient grounds to deny initial approval or to immediately suspend privileges.

(vi) any refusal that continues for more than thirty (30) days after the date of the automatic suspension shall result in automatic termination of privileges.

(h) a Supervising Practitioner who is a Member of the Active or Courtesy Medical Staff, if the Allied Health Professional is not an employee of Texas Health Harris Methodist Hospital Fort Worth.

14.4 Rules for All Allied Health Professionals

(a) Supervising Practitioner for Allied Health Professionals

The services of an Allied Health Professional shall be engaged by a Member of the Medical Staff either as an employee of the Practitioner, the medical group or as an independent contractor. Such Member shall be identified as the "Supervising Practitioner."

Any Member of the Active or Courtesy Medical Staff is eligible to supervise and shall assume total responsibility for the performance of any Allied Health Professional under supervision.

Should the relationship of the Allied Health Professional and the Supervising Practitioner be terminated, it shall be the responsibility of the Supervising Practitioner to immediately notify the Medical Staff office of such termination and the privileges of such Allied Health Professional shall be suspended immediately upon receipt of such notification.

Should the staff membership of the Supervising Practitioner be terminated, the privileges of the Allied Health Professional shall be suspended immediately upon such action.

In either instance, the Allied Health Professional shall have thirty (30) days in which to identify an alternative approved Medical Staff Member to assume the responsibilities of Supervising Practitioner. If such alternative Supervising Practitioner is not identified, the privileges of the Allied Health Professional shall automatically lapse.

In the case of Allied Mental Health Professionals and Psychologists, the "Supervising Practitioner" shall be the physician who is attending the patient on a case and who is requesting the consultation.

(b) Bound by Rules and Regulations and Policies

Each Allied Health Professional, in connection with submitting an application, shall verify by written statement that Section 14 of the Rules and Regulations governing Allied Health Professionals at the Hospital has been read, understood and, also, agrees to be subject to and abide by such provisions.

While at the Hospital, all Allied Health Professionals shall be governed by the general policies of the Hospital, as well as by specific policies relating to delivery of services and conduct of care by Allied Health Professionals.

(c) Name Tags

Each Allied Health Professional shall wear an identification tag at all times while on the Hospital premises. Such name tags shall bear the Professional's name, professional designation, such as "R.N." or other appropriate title. No such name tag shall bear the words "Texas Health Harris Methodist Hospital Fort Worth" or any abbreviation thereof, unless the Allied Health Professional is an employee of the Hospital and is functioning as such. Failure to wear such identification shall be grounds for disciplinary action.

(d) Provisional Status

Each Allied Health Professional shall serve a one year provisional period during which time they shall be subject to proctoring as defined in 14.5(g) below.

14.5 Procedures for Authorization, Renewal and Revocation

(a) Application Forms

Application forms to be used in applying for authorization or renewal of authorization to act as an Allied Health Professional shall be developed and provided by the Medical Staff Office. Such office shall be responsible for processing the applications unless the Allied Health Professional is contracted and credentialing has been delegated under such contract.

The Medical Staff office shall maintain records of applications received, applications in process, current authorized Allied Health Professionals, and the disposition of applications not resulting in authorization.

(b) Processing Applications

Upon receipt, an application shall be examined for completeness, the information contained therein shall be verified and the application, when complete and verified, shall be referred to the Credentials Committee.

All application forms and requests for privileges are subject to review, as appropriate, by nurse managers or other individuals and the approval of the Division Chief, Credentials Committee, Medical Board and Board of Trustees.

(c) Temporary Approval

Once a completed application has been received, the information contained therein verified, and approval has been recommended by the Credentials Committee, temporary (conditional) approval of the Allied Health Professional's authorization to act can be granted by any two of the following persons:

(i) appropriate Nursing Manager, and
(ii) appropriate Division Chief, and
(iii) Chairman or Vice Chairman of the Credentials Committee.

(d) Review by Committee

The Credentials Committee shall consider the application, make any further investigation or inquiry as it may deem advisable and shall recommend approval or disapproval of the professional seeking authorization or renewal of authorization and all specifically authorized acts or limitations on the service of the professional.

(e) Approval by Medical Staff and Board of Trustees

An Allied Health Professional shall hold only temporary (conditional) authorization until the recommendation has been reviewed and acted upon by the Medical Board and the Board of Trustees. Once approved by the Board of Trustees, the Allied Health Professional will serve a one (1) year provisional period. Provisional Staff status may be extended for any period which does not extend beyond the end of a second one (1) year period if the required number of cases or other criteria has not been met. Membership and privileges will automatically terminate at the end of the second one (1) year period and such member shall not be eligible to reapply for membership and privileges for a period of one (1) year from the date of the automatic termination. Any Allied Health Professional whose authorization has expired or is not renewed may not provide any services in the Hospital.

(f) Supervision of Allied Health Professionals

The respective Department(s) in which the Allied Health Professional performs privileges shall monitor the performance of the Allied Health Professional. The Departments shall regularly report such monitoring activities to the appropriate Division Quality Review Officer/Committee and to the Credentials Committee.

(g) Renewal and Revocation

Each Allied Health Professional who is currently authorized to perform specific duties within the hospital shall be notified no less than one hundred twenty (120) days prior to the expiration of such authorization. A copy of such expiration notice will be sent to the Allied Health Professional's employer, if such employer is a Member of the Medical Staff or a Professional Association or Clinic, whose members are Members of the Medical Staff, or to the Supervising Practitioner.

If any Allied Health Professional does not return a request for renewal of authorization on a timely basis, the authorization shall lapse. Any Allied Health Professional whose authorization has lapsed shall not be granted temporary or interim Authorization to Act and shall not perform any acts until the authorization has been acted upon by the Board of Trustees.

The Credentials Committee shall review the performance of Allied Health Professionals no less often than once every two years and no less often than that of their hospital-employed counter parts.

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All Allied Health Professional will be required to submit either five (5) cases or two (2) references from THR nursing supervisors who can adequately evaluate their performance for renewal of authorization. The Allied Health Professional's privileges will expire at the end of every two (2) year period. The Medical Staff office shall determine an administratively appropriate reappointment and evaluation schedule, subject to the approval of the Credentials Committee

The Credentials Committee shall recommend that any Allied Health Professional's approval be terminated at any time when it is believed such Professional's continued service at the Hospital may in any way disrupt or endanger good patient care, or that such termination is in the interest of the orderly administration of the Hospital.

(h) Emergency Revocation of Authorization

The authorization of any Allied Health Professional may be revoked at any time by the Administrator of the Hospital, the Chairman of the appropriate Division of the Medical Staff, or the Chief or Vice Chief of the Medical Staff when in the opinion of such person, the failure to take such action might in any way result in a threat to the health or welfare of any patient or other person or to the orderly administration of the Hospital.

(i) Notice of Adverse Recommendation or Action

After being advised that an Allied Health Professional (who is not an employee of the Hospital) has not been approved, such approval has been lost, revoked or not renewed pursuant to (g) and (h) above, the Chief of Staff shall promptly provide the Allied Health Professional special notice of an adverse recommendation or action taken pursuant to (g) and (h) above. The notice shall (1) advise of the right to request an appeal pursuant to this section, (2) advise the Allied Health Professional that there are (10) ten days allowed after receiving the notice within which to submit a request for an appeal to the Chief of Staff in person or by certified or registered mail, (3) advise the Allied Health Professional that the right to appeal will be forfeited if the Allied Health Professional fails to request such appeal or fails, without good cause, to appear at the scheduled appeal, (4) advise the Allied Health Professional of the right to receive an explanation of the decision made and to submit any additional information the Allied Health Professional deems relevant to the review and appeal of the decision, and (5) advise the Allied Health Professional that upon completion of the appeal, the Allied Health Professional involved has the right to receive a written decision from the Hospital, including a statement of the basis of the decision.

(j) Appeal Procedure

When an Allied Health Professional requests an appeal, the appeal shall consist of a single meeting with the Allied Health Professional and Medical Board. The Allied Health Professional shall not be entitled to be accompanied to such meeting by any individual other than the Supervising Practitioner (if applicable).

During the meeting, the basis of the adverse decision which gave rise to the appeal will be reviewed with the AHP, and the AHP will have the opportunity to present any additional information the Chief of Staff deems relevant to the review and appeal of the decision. Following the meeting, the Medical Board will make a recommendation to the Board of Trustees to maintain, revise or modify the decision of the Credentials Committee. The AHP will receive a written decision from the Hospital stating the results of the appeal and the basis of the decision after consideration of the Medical Board's recommendation by the Board of Trustees.

The Allied Health Professional shall not be entitled to any further hearing, appeal, or other proceeding.

Nothing set forth above shall be deemed to deny an Allied Health Professional the right to engage or be advised by legal counsel. However, attendance by legal counsel at the appeal meeting shall not be allowed.

(k) Time to Reapply After Termination

If the Allied Health Professional's authorization has been terminated, at least two (2) years must pass before re-requesting authorization, if the termination was not voluntary.

15.0 MEDICAL STUDENTS, RESIDENTS, FELLOWS

15.1 The Graduate Medical Education Committee shall have the responsibility for monitoring all aspects of residency education, maintain records as required by accreditation bodies or applicable laws, and report to and advise the Medical Board and the Board of Trustees on all issues covering graduate medical education at the hospital. It will oversee and support compliance with Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME). The committee shall provide to the medical staff written descriptions of the roles, responsibilities and patient care activities of the participants of all graduate medical education programs. These descriptions will include identification of mechanisms by which the supervisor (s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

15.2 All students/residents/fellows shall be registered in the Medical Staff Office prior to beginning any work at the Hospital. The Medical Staff Office will be informed of the expected duration of their preceptorship/observation in the Hospital. The practitioners with whom they are training must have a license commensurate with that trainee's anticipated degree or specialty of practice.

15.3 Students/residents/fellows shall introduce themselves, and their status, to any patient with whom they come in contact and a verbal consent regarding participation in care shall be obtained from the patient. All students/residents/fellows must wear a hospital-issued badge identifying themselves as such.

15.4 Students/residents/fellows who are part of an approved, formalized preceptor program recognized by the Medical Staff and approved by the Board may be permitted to perform procedures, assist in surgery, and render other aspects of patient care in the Hospital under the direct supervision of the preceptor and to an extent consistent with the privileges of the preceptor and within the limits of the student/resident/fellow's abilities as identified by the sponsoring institution.

15.5 Residents/fellows training at the Hospital shall not hold appointments to the Medical Staff and will not be granted specific Clinical Privileges. They are permitted to perform only those functions set out in training protocols developed by the respective residency/fellowship programs and approved by the Credentials Committee, Medical Board and the Board of Trustees. The residency/fellowship program is responsible for verifying the qualifications and credentials of each resident/fellow permitted to function in the Hospital. The care of the patient shall be the responsibility of the member. Residents/fellows may participate as ex-officio appointees of the Medical Staff and Divisions for the purpose of education as to peer-review and administrative responsibilities.

15.6 Residents/fellows may write and dictate history and physical examination reports, operative reports, and discharge summaries, which must be reviewed and countersigned

by the preceptor physician. Medical students may write progress notes which can serve as accepted progress notes if countersigned by the preceptor physician.

15.7 Appropriately precepted student healthcare practitioners may write orders in the presence of a duly licensed and privileged practitioner, but the orders may not be implemented until they are countersigned by the practitioner. Residents/fellows may write orders which must be countersigned by the attending physician within 48 hours.

15.8 For a formal preceptorship, the sponsoring institution will provide the Medical Staff and the Hospital with the objectives of the program, as well as evidence of liability coverage. In addition, they will indicate the general level of a student/resident/fellow's clinical abilities and the time frame of the preceptorship.

15.9 The Medical Staff Credentials Committee shall be informed of those residents and fellows that are fulfilling preceptorship in the Hospital. The preceptor must be an Active member of the medical staff.

16.0 HOSPITAL EMPLOYEES SUBJECT TO MEDICAL STAFF QUALITY REVIEW

In certain situations it may be necessary for a Registered Nurse to carry out procedures historically performed by Physicians. The nurses designated below shall have the demonstrated competence to carry out certain specific tasks under the supervision of a physician. The additional training and/or experience providing such competence shall be reviewed by the responsible Medical Staff Committee and/or Medical Director listed below. The Committees and/or Medical Director shall report to the Medical Board and the Board of Trustees.

(a) **Obstetrical Nurses:**

(i) Responsible Medical Staff Committee: Nursery/OB Policy Committee

(ii) Designated Nurses: Clinical Service Manager, Clinical Service Coordinator, Clinical Educator-Outreach Coordinator and Staff Nurse

(iii) Procedures:

- Emergency Episiotomy
- Attachment of scalp electrode for fetal monitor
- Intrauterine Pressure Catheter (IUPC)

(b) **Critical Care Nurses, ICU Nurse Manager, House Supervisors, and Cardiovascular Clinicians**

(i) Responsible Medical Staff Designee: Appropriate Medical Staff Division

(ii) Designated Nurses: ICU Managers, Critical Care Nurses (after completion of Advance Cardiac Life Support course), House Supervisors, and Cardiovascular Clinicians.

(iii) Procedures:

- Initiation of routine emergency treatment of pulmonary arrest, i.e., initiation of routine emergency treatment for cardiopulmonary arrest

- Initiation of blind defibrillation in the pulseless, lifeless patient

(iv) Designated Nurses: Selected Approved Registered Nurses

(v) Procedures:

- Arterial punctures
- Withdrawal of blood from Swan-Ganz thermodilution catheter
- Inflation of Swan-Ganz balloon and withdrawal of catheter on physician's orders
- Withdrawal of cerebral spinal fluid via intracranial catheters or screws

(c) **Flight Nurses:**

(i) Responsible Medical Staff Committee: Emergency Medicine Committee.

(ii) Designated Nurses: Selected Approved Registered Nurses.

(iii) Procedures as defined by established protocols, and as approved by the appropriate Medical Staff Committees and the Medical Board. Additional privilege requests will be submitted and approved through the appropriate Medical Staff process.

(d) **Oncology Nurses:**

(i) Responsible Medical Staff Committee: Cancer Committee

(ii) Designated Nurses: Oncology Clinical Nurse Specialist, Nurses with advanced skills and competence in Chemotherapy Therapy Administration

(iii) Procedures:

- Administration of chemotherapy drugs (vesicant or non-vesicant) given IV push or IV piggyback.

(e) **Neonatal Nurse Clinicians:**

(i) Responsible Medical Staff Committee: Nursery/OB Policy Committee

(ii) Designated Nurses: Neonatal Nurse Clinicians

(iii) Procedures:

- Intubation
- Umbilical artery or vein catheterization
- Resuscitation and stabilization
- Surfactant administration