children's health
Children's Medical Center
Dallas

RULES

AND

REGULATIONS

OF THE

MEDICAL / DENTAL STAFF

children's health
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SECTION 1. Admission, Transfer and Discharge of Patients

1.1. A patient may be admitted to Children's Medical Center of Dallas ("Children's Dallas" as defined in the Medical/Dental Staff Bylaws) only by a member of the Medical/Dental Staff having admitting privileges. A member of the Medical/Dental Staff may, in the course of caring for a patient, request that the patient be admitted to a different medical or surgical service. In that case, the referring Medical/Dental Staff member is responsible for conducting an appropriate hand-off of care.

1.2. Except in an emergency situation, no patient shall be admitted to Children's Dallas without a provisional diagnosis or valid reason for admission being stated. In the case of an emergency, this information shall be recorded in the medical record as soon as possible after admission.

1.3. In situations where there is a transfer of attending responsibilities between two providers, the accepting provider is responsible for confirming the attending designation within the electronic medical record has been changed.

1.4. If an unforeseen inpatient emergency arises and the patient's physician/dentist cannot be contacted, the appropriate Division Director shall be contacted, and the appropriate chain of command shall be followed.

1.5. Children's Dallas is a setting for the education of Residents, Fellows and medical students. While patients at Children's Dallas may be evaluated and treated by Residents, Fellows or medical students, the attending physician/dentist is responsible for the supervision of medical/dental care provided to the patient. Residents, Fellows and medical students must comply with the policies established by Children's Dallas and University of Texas Southwestern Medical Center ("UT Southwestern").

1.6. Except as otherwise provided in Children's Dallas policies, no patient shall be transferred within Children's Dallas without the approval of the attending physician/dentist, with the exception of a critically ill or infectious patient who requires immediate relocation to protect him/her self or others. In case of an emergency, the attending physician shall be notified as soon as he or she can be reached.

1.7. When a patient is being transferred to another hospital or other health care facility, the attending physician shall follow Children's Dallas transfer policy and procedures and all applicable state and federal laws governing patient transfers.

1.8. If the patient is considered to be a source of danger to him/her self or others, the admitting physician shall be responsible for providing such information as may be necessary to protect the patient from self-harm and harm to other patients, staff or visitors as defined by hospital policy.

1.9. Any patient who is evaluated in the Emergency Department (ED) or is being admitted to or is already an inpatient at Children's Dallas, and who is known or suspected to be suicidal, has taken a chemical/drug overdose, or is otherwise suspected to exhibit intentional self-harm behavior, shall have a mental health assessment. The assessment may be performed by a mental health clinician (LCSW, LPC, LMFT, PhD, MD or DO) who will provide the findings of that assessment to the ED attending or the patient's treating physician. The attending will determine if additional psychiatric consultation is needed. If this assessment is refused by the patient, parent or other authorized party, the medical record shall indicate that the assessment was recommended, offered, and refused. A referral shall be made by the physician to Child Protective Services, if appropriate, and necessary suicide prevention precautions shall be taken according to Children's Dallas policy and procedure.

1.10. The patient shall be discharged only on the written order of the attending physician, Resident, Fellow or an authorized Advanced Practice Professional ("APP") defined as an advanced practice registered nurse ("APRN"), physician assistant ("PA"), certified registered nurse anesthetist ("CRNA") or certified anesthesiologist assistant ("CAA") authorized by the attending physician. If a patient leaves Children's Dallas against medical advice ("AMA"), the patient, parent or other authorized party shall be requested to sign an AMA release. If a release cannot be obtained, document the refusal and leaving AMA in the patient's medical record along with any reason given, and witnessed by an employee. A patient leaving Children's Dallas AMA without signing the appropriate document(s) shall be considered to be officially discharged AMA.

1.11. The attending physician, Resident, Fellow, or APP authorized by the attending physician shall discharge the patient as soon as medically appropriate. Pre-Discharge orders shall include, but not limited to, medications, patient teaching requirements, and follow-up appointments.

1.12. Physicians/dentists shall abide by admitting/discharge requirements that have been delineated in other sections of these Rules and Regulations or applicable Policies and Procedures.

1.13. Admitting physicians/dentists shall:

1.13.1. Refer elective cases to the Admitting Office for advance arrangements;

1.13.2. Complete reports required to secure payment of insurance or compensation claims by Children's Dallas;

1.13.3. Record information required for Children's Dallas billing; and

1.13.4. Adhere to Children's Dallas admitting policies and procedures.

SECTION 2. Medical Records

2.1. General Medical Record Practices

2.1.1. The attending physician/dentist is responsible for the preparation of an accurate, timely, complete and legible medical record for each patient. The medical record shall be sufficiently detailed and organized to enable another physician/dentist to assume the care of the patient at any time and to enable the retrieval of pertinent information required for quality assurance/improvement and utilization review activities. The medical record shall contain sufficient information to: identify the patient; support the diagnosis/condition; justify the care, treatment, and service; document the course and results of care, treatment, and service; and promote continuity of care among providers.

2.1.1.1. The contents for inpatient admission records shall include but not be limited to: identification data; a history and physical; a plan of care; patient orders; all required consent forms; special reports such as laboratory (clinical laboratory/pathology), radiology, and electrocardiography; treatment; progress notes; operative or procedure reports; consultations; condition on discharge; discharge summary; final diagnosis; and, if performed, an autopsy report. As appropriate, an anesthesia record and any patient, parent, or other authorized party's instructions/education shall be documented in the medical record.

2.1.1.2. The contents for an outpatient record shall include, but not be limited to identification data; appropriate consent forms; appropriate reports; provisional diagnoses; documentation of the medical or surgical treatment; any patient/family instructions/education; a continuity of care list by the third visit (if applicable to the area); condition on discharge or transfer; and a note summarizing the case.

2.1.2. The use of scribes for the purposes of medical transcription into the medical record shall be limited to those scribes who are approved and authorized through an appropriate contractual relationship.

2.1.2.1. The attending medical/dental staff member is ultimately responsible for all medical record documentation entered by the scribe. Scribes act under the direct supervision of an attending medical/dental staff member; they may not act independently. A scribe may document the previously determined medical/dental staff member's dictation and/or activities.

2.1.2.2. A scribe is not permitted to accept, transcribe into the medical record or implement orders, including verbal orders.

2.1.2.3. All entries into the record by a scribe shall include the following:

- Name and title of scribe, date, time and signature of scribe
- Name of attending physician or APP on whose behalf the scribe is entering documentation

2.1.2.4. The attending medical/dental staff member must authenticate all documentation entered into the record by a scribe by making a separate entry to confirm his or her agreement with the contents of the entry (date, time and attending signature required).

Authentication must take place before the physician and scribe leave the patient care area and prior to the patient being admitted, transferred to the operating room or other treatment area within the hospital or transferred to an outside health care facility for further evaluation. Authentication for patients being discharged must be completed according to the process defined in Section 2.6.1. Authentication by the attending cannot be delegated

2.1.3. Written authorization from the patient, parent or other authorized party is required for release of medical information to persons not otherwise authorized to receive this information.

2.1.4. The medical record, including but not limited to imaging files, pathology slides and test results, is the property of Children's Dallas and shall <u>not</u> be removed from Children's Dallas premises without a release from the Health Information Management Department, except as outlined in Section 6.24. Unauthorized removal of medical records from Children's Dallas by any person is grounds for suspension of the person for a period to be determined by the Medical Executive Committee of the Medical/Dental Staff.

2.1.5. In case of readmission of a patient, all previous records shall be available for the use of the attending physician or dentist. This shall apply whether the patient is attended by the same physician/dentist or by other physicians/dentists.

2.1.6. Subject to applicable laws, access to all medical records of all patients shall be afforded to members of the Medical/Dental Staff for research, consistent with preserving the confidentiality of personal information concerning the individual patients. All research projects must be approved by the Institutional Review Board ("IRB") before the medical records can be studied.

2.1.7. Medical records shall not be permanently filed until completed by the attending medical/dental staff member or ordered to be filed by the Health Electronic Record/Health Information Management Committee of the Medical/Dental Staff. An incomplete record will not ordinarily be filed if the attending physician/dentist is still a member of the Medical/Dental Staff or holds clinical privileges at Children's Dallas. No physician or dentist shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the physician/dentist who is responsible for completing the record. Any physician/dentist whose privileges are suspended or relinquished per the Medical/Dental Staff Bylaws and/or the Medical/Dental Staff Rules and Regulations for delinquent records or who resigns from the Medical/Dental Staff without adequately completing all medical records will not be reinstated or allowed to reapply for Medical/Dental Staff membership until such records are satisfactorily completed.

2.1.8. Physicians or dentists who are going to be on a leave of absence or vacation must arrange in advance for an extension from the Health Information Management Department regarding completion of medical records, if necessary.

2.1.9. An addendum/correction shall be documented to correct erroneous entries in electronic documentation. For any paper record, if an error is made on an entry in the medical record, a single line shall be drawn through the word(s) and "error" or "void" written near it. The error is not to be obliterated, whited out, or erased. The approved practitioner initials shall be noted above the erroneous entry. The correct entry shall then be written in with the date and time, then signed or authenticated, according to Children's Dallas policy, by the approved practitioner.

2.1.10. All medical record entries shall be dated, timed, identified by author's name, credentials indicated and signed or authenticated electronically, with

stamped or legibly printed name, according to Children's Dallas policy. The attending physician must countersign all histories and physical examinations, operative reports, discharge summaries, consultations, anesthesia records, radiology reports, pathology reports, and autopsy reports written by Residents and Fellows or APPs practicing in an inpatient setting. See section 3.8 for additional countersignature requirements.

2.1.11. Any document filed in a patient's medical record shall be the original, a faxed copy, or a photocopy legible in its entirety.

2.1.12. Only black or blue ink shall be used for documenting in any medical record.

2.1.13. Any use of handheld mobile devices, smart phones and/or tablets must use Children's Dallas' approved applications and tools when accessing protected health information.

2.2. History and Physical

A. Minimum History and Physical Requirements:

2.2.1. A physician member of the Medical/Dental Staff shall be responsible for the medical care and treatment of each patient at Children's Dallas. All patients shall have a history and physical examination completed and documented in the medical record by a physician member of the Medical/Dental Staff with clinical privileges or licensed individual approved for such privileges based on demonstrated clinical competence.

2.2.2. A complete history and physical shall consist of the following: chief complaint; history of present illness; medications; allergies; relevant past medical, surgical, family, and social history; review of systems; pertinent diagnostic results; assessment and plan of care.

2.2.3. The extent of the physical examination performed is dependent on clinical judgment and the nature of the presenting problem. At a minimum it shall contain, vital signs, cardiovascular, pulmonary/respiratory, and relevant physical examination of areas of the body relevant to the chief complaint. These requirements relate only to the inpatient setting. Outpatient notes should have physical exam findings appropriate to the patient need.

B. Time Frame for Completion of History and Physical:

2.2.4. All inpatients shall have a complete history and physical documented and signed/co-signed in the medical record within twenty-four (24) hours of admission.

2.2.5. For all elective surgical procedures and ambulatory (same-day) surgery patients, the history and physical shall be documented at the time of admission and prior to the patient leaving the pre-procedural area, unless an emergency situation exists.

2.2.6. Elective inpatient or outpatient surgery shall be canceled or delayed until a complete history and physical examination is completed and documented in the medical record.

2.2.7. A complete Pre-Anesthetic Summary and/or Sedation Assessment can be considered the history and physical for outpatient, non-invasive procedures.

2.2.8. A new history and physical must be completed if the original history and physical was performed and completed greater than thirty (30) days prior to admission, registration, or a procedure. If the original history and physical was performed and completed within the past thirty (30) days (prior to admission, registration or a procedure), there must be evidence of an updated examination of the patient, including any changes in the patient's condition – this is called an interval note.

C. History and Physical Countersignature and Pre-Procedural Requirements:

2.2.9. When a history and physical examination is recorded in the medical record by a Resident, Fellow, or an authorized APP, for any elective procedure requiring more than local anesthesia, the supervising physician/dentist shall complete the following prior to the patient leaving the pre-procedural area:
review the history and physical
make a separate entry to indicate his/her approval and agreement with the contents, or document any revisions that he/she may have
countersign or authenticate the history and physical
ensure informed consent has been obtained in accordance to Children's Dallas Informed Consent Policy and sign the consent form.

2.2.10. Inpatient history and physicals recorded in the medical record by a Resident, Fellow or an authorized APP must be countersigned by the attending physician within twenty-four (24) hours of admission.

2.2.11. For APPs practicing in an ambulatory clinic setting or the emergency department, the history and physical, procedural reports and consultations do not require an attending countersignature.

2.3. Progress Notes

2.3.1. Progress notes shall be entered by the attending physician/dentist at least daily on all patients, except as stated below in Section 2.3.1.1. When a progress note is entered by an APP or resident/fellow, the attending physician/dentist may enter an attestation to the note. The attestation entered by the attending shall qualify as the progress note.

2.3.1.1. Progress notes for all patients of the outpatient psychiatry program shall be documented by the attending physician at least weekly and shall clearly document any change in the treatment plan or condition of the patient.

2.3.2. Pertinent progress notes shall be recorded at the time of observation to provide for continuity of care and transferability. They should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. The patient's clinical problems should be clearly identified and correlated with specific orders as well as test, procedure, and treatment results.

2.4. Operative Reports

2.4.1. An operative report shall be completed and signed/co-signed in the medical record upon completion of the operative or high-risk procedures before the patient is transferred to the next level of care. The operative report shall contain the name(s) of the primary surgeon(s) who performed the procedure and his or her assistant(s), pre-operative diagnosis, indications for the procedure, name of the procedure performed, a full description of the procedure, findings of the procedure, any intra-operative complications, estimated blood loss, any specimen(s) removed, and the post-operative diagnosis. The operative report must be signed or authenticated by the surgeon and filed in the medical record as soon as possible after the surgery.

2.4.2. When a full operative report cannot be entered immediately into the patient's record after the operation or procedure, a brief operative note shall be entered in the medical record before the patient is transferred to the next level of care. The brief operative note shall contain the name(s) of the primary surgeon(s) and his or her assistant(s), pre-operative diagnosis, name of the procedure performed, findings of the procedure, estimated blood loss, any specimens removed, and postoperative diagnosis. If a brief operative note is written, the full operative report shall be completed and signed/co-signed within twenty-four (24) hours.

2.5. Discharge Summary

2.5.1. A discharge summary shall be completed and signed/co-signed on all medical records of patients hospitalized more than forty-eight (48) hours. A final progress note shall suffice for all admissions less than forty-eight (48) hours. In all instances, the content of the medical record must be sufficient to justify the diagnosis, warrant the treatment and end result, and address any pertinent instructions to the patient, parent, or other authorized party. A complete summary is required on all deaths. All summaries shall be signed or authenticated, according to Children's Dallas policy, by the attending physician or dentist.

2.5.2. The discharge summary shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition and disposition of the patient at discharge, information provided to the patient, family, or other authorized party, and provisions for follow-up care. The condition of the patient on discharge shall be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague terminology such as "improved", "satisfactory", "good", etc.

2.5.3. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within two (2) working days. The final autopsy report should be made part of the medical record no later than sixty (60) working days after the autopsy, barring requirements for offsite or complex testing.

2.6. Attending Dentist Medical Records

2.6.1 Specifically for dental procedures/surgeries, the dentogram shall be completed by the attending dentist on the day of the case and included in the patient's medical record as soon as possible after the procedure/surgery. At a minimum, the dentogram shall contain, when applicable, the name and signature of the primary attending dentist, date/time of the procedure/surgery, teeth present, occlusion, soft tissue examination, notation of radiographs taken in the private office and/or intraoperative radiographs, and the completed treatment.

2.6.2 Attending dentists shall be responsible for documenting a history and physical examination relative to the dental problem. Any medical problem present on admission, or arising during the hospitalization of a dental patient, that is considered outside the scope of a dentist's privileges, shall become the responsibility of an attending physician member of the Medical/Dental Staff upon acceptance after consultation with the attending dentist.

2.6.3 Dental imaging taken within the hospital shall remain the property of Children's Dallas and shall be included in the patient's medical record. A copy of the pre-operative images taken in a dentist's private office in preparation for a dental procedure/surgery at Children's Dallas shall be provided by the dentist and included as part of the patient's medical record.

2.7. Incomplete/Delinquent Medical Records

2.7.1. The patient's inpatient, emergency room, and day surgery medical record, as appropriate to the service delivery, shall be completed at the time of discharge, including progress notes, final diagnosis, discharge instructions/summary, and appropriate signatures. Outpatient records shall be completed contemporaneously with the patient's visit.

2.7.1.1. Incomplete records are defined as those records that are lacking any appropriate signatures and/or reports.

2.7.1.2. Delinquent records are those records deemed to be incomplete within seven (7) calendar days after discharge.

2.7.2. Delinquent operative reports are defined as those reports not completed and signed/co-signed within 24 hours following the surgery/procedure.

2.8. Automatic Suspension and Relinquishment of Privileges

2.8.1. The privileges of attending physicians, dentists, or APPs shall be suspended if medical records become delinquent as defined in section 2.6. for greater than fourteen (14) calendar days.

2.8.2. Additionally, the Medical Executive Committee of the Medical/Dental Staff shall be notified promptly if any physician or dentist has had his/her elective privileges suspended because of delinquent medical records five (5) times in a rolling twelve (12) month period.* In such cases, the Medical Executive Committee of the Medical/Dental Staff shall consider recommending to the Board that the attending physician's or dentist's privileges be revoked. Failure to complete the delinquent records within three (3) calendar months after the date the automatic suspension became effective shall be deemed a voluntary resignation from the Medical/Dental Staff and all privileges are deemed to have been voluntarily relinquished as outlined in Article XI of the Medical/Dental Staff Bylaws.

*One suspension period shall not exceed four (4) consecutive weeks. If a physician or dentist remains on the suspension list for more than four (4) consecutive weeks, the suspension period shall renew and count as an additional suspension period.

2.9 Organ and Tissue Donation

2.9.1 The medical records of the donor and recipient shall fulfill the requirements of any surgical inpatient medical record when an organ is obtained from a live donor.

2.9.2 When an organ is removed from a cadaver for transplantation, a report that includes a description of the technique used to remove and prepare or preserve the donated organ shall be documented in the medical record. This report shall be made part of the recipient's medical record.

2.9.3 When a donor organ is obtained from a brain-dead patient, the medical record of the donor shall include the date and time of the determination of brain death, documentation by and identification of the physician who determined the brain death, the method of transfer of the organ or tissue, and the treatment provided to the brain-dead donor, as well as an operative report.

2.9.4 Informed consents for the removal and/or transplantation of donor organs or tissues must be filed in the donor's medical record.

SECTION 3. Orders

3.1. All patient orders shall be entered in the medical record by an attending medical/dental staff member, resident, APP, or another provider who is providing care to the patient, and who, in accordance with Children's Dallas policy; law and regulation; and Medical/Dental Staff Bylaws and Rules and Regulations, is authorized to write orders.

3.2. A verbal order shall be considered to be "in writing" if dictated to a duly authorized individual and signed, dated, and timed or authenticated, according to Children's Dallas policy, by the attending Medical/Dental Staff member, Resident, Fellow, or APP. The attending Medical/Dental Staff member, Resident, Fellow, APP, or another provider who is providing care to patient, and who, in accordance with Children's Dallas policy; law and regulation; and Medical/Dental Staff Bylaws and Rules and Regulations, is authorized to write orders, must sign the verbal order within

ninety-six (96) hours. The signature must be dated and timed. Verbal orders should be limited to: situations in which a delay in treatment poses a risk to the patient; or there is a need to clarify a written order; or to optimize care along the continuum. All verbal orders must be "read back" to the provider for accuracy.

3.2.1. The authorized individual shall: 1) record the order; 2) make note of the name of the ordering physician/dentist, or APP; 3) record the date and time of the order; and 4) sign the order. Verbal medication orders may be received only by licensed nurses (RN or LVN/LPN), registered pharmacists, and, when approved by the Medical/Dental Staff for limited use in their respective specialties, by licensed/registered/certified respiratory therapists, and cardiopulmonary technologists functioning within their scope of licensure/competence. Verbal orders for specific therapy shall be received only by licensed nurses (RN or LVN/LPN) and, when approved by the Medical/Dental Staff, by licensed/registered/certified laboratory technologists, cardiopulmonary technologists, physical therapists, speech therapists, audiologists, occupational therapists, and respiratory therapists, when functioning within their scope of licensure/competence. Verbal orders shall be received only from members of the medical/dental staff with clinical privileges and/or APPs, Residents and Fellows functioning within their scope of practice (outside of the ICU).

3.2.2 Only an attending Medical/Dental Staff member, fellow, or APP can give a verbal or telephone order in any of the Intensive Care Units or Emergency Department.

3.3. Any standing medical order, standing delegation order, or medical protocol needs to be co-signed within ninety-six (96) hours by the Attending Physician, Resident, Fellow, APP, or another provider who is responsible for the patient's care and who is authorized to write orders in accordance with Children's Dallas policy, applicable laws and regulations, and the Medical/Dental Staff Bylaws and Rules and Regulations. The signature must be dated and timed. A copy of the standing delegation order or medical protocol shall be included in the patient's medical record.

3.4. Physician/dentist and APP orders shall be documented in the electronic medical record. Orders documented on paper shall be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly or understood by the nurse, technologist, therapist, dietitian, etc. The use of "renew", "repeat", or

"continue" orders is not acceptable. Orders must be specific. Only approved hospital abbreviations may be used in the documented orders.

3.5. "DO NOT RESUSCITATE" and "LIMITED RESUSCITATION (PARTIAL CODE) orders must be entered by the attending physician (as outlined in the Children's Dallas policy on withholding/withdrawing of resuscitative services or life-sustaining treatment) in the medical record. The attending physician must verify in the medical record that the patient, parent, or other authorized party has 1) been fully apprised of the patient's condition; 2) consented to the "DO NOT RESUSCITATE" or the "LIMITED RESUSCITATION (PARTIAL CODE)" order, and 3) been notified of the issuance of the order.

3.5.1 For inpatients, orders are valid for the duration of the current admission, unless revoked. If the patient is discharged and readmitted, a new order must be entered in the medical record.

3.6. All orders, including DNR and Limited Resuscitation Orders, shall be canceled at the time the patient undergoes surgery unless otherwise directed by the attending surgeon and anesthesiologist.

3.7. Orders shall be re-documented for patients transferred to a lesser or higher level of care, e.g., from a special care unit to a medical-surgical nursing unit or vice versa, or from outpatient to inpatient status.

3.8. Residents, Fellows, and APPs may document orders (except as specified in Section 3.9) in the medical record.

3.9. Orders for oncologic chemotherapy, when documented for treatment of patients with a malignancy, require two signatures prior to administration of medication, one of which must be an attending physician. An Oncology Fellow, or APP can be the secondary signature. Residents may not document orders for oncologic chemotherapy.

SECTION 4. Medication Management

4.1. All medications administered to patients shall have been approved by the Food and Drug Administration. Specific approval for pediatric use is not required. The only exceptions are those medications administered under a protocol for investigational or experimental medication use that has been approved by the Institutional Review Board ("IRB"). When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically are not defined as a medication, administration of these substances shall also be in accordance

with an established protocol that has been approved by the Medical/Dental Staff through its designated mechanism.

4.2. Investigational or experimental medications shall be used only under the direct supervision of the principal investigator who shall be a physician/dentist member of the Medical/Dental Staff with clinical privileges and who shall be responsible for securing the necessary consents.

4.3. Access to basic information concerning the medication including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known, shall be provided to all individuals preparing or administering investigational medications.

4.4. The pharmacy shall store all investigational medications used at Children's Dallas and be responsible for labeling and dispensing in accordance with the physician/dentist investigator's written orders.

4.5. Medication administration by parents is only performed as part of a teaching program for home use.

4.6. It is the policy of Children's Dallas that only medication dispensed through Children's Dallas pharmacy may be used at Children's Dallas. Under special circumstances, the hospital pharmacist may identify the need for medications from other sources that are required for the care of the patient. In such cases, the attending physician/dentist, Resident, Fellow, or APP must clearly specify the use of each of these medications in documented orders in the medical record. These medications will be procured, stored and dispensed by the pharmacy.

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

4.8. The use of "prn" and "on call" in a medication order must be qualified by dosage, indication, and dosing interval.

4.9. All standing orders for medications shall be initially evaluated and, if approved, shall be reevaluated at least annually thereafter by the Pharmacy & Therapeutics Committee.

4.10. The pharmacy may substitute generic equivalent medications unless specifically noted otherwise on the order form. Non-formulary medications must be obtained through the approval processes.

4.11. Medication samples may only be distributed by the pharmacy in accordance with the Medication Management Policies.

4.12. Physicians/dentists shall abide by medication requirements that have been delineated in other sections of these Rules and Regulations and applicable Medical/Dental Staff and Children's Dallas policies because of their relevance to the subject matter in those sections.

4.13. When, in the opinion of a member of the nursing staff or the pharmacy, a medication dosage ordered represents a potential hazard to the patient (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition), and the prescribing provider disagrees, the Division Director to which the prescribing provider is assigned, the Chair of the Pharmacy & Therapeutics Committee, or the Vice President, Medical Staff Affairs shall be consulted by the nursing staff member or pharmacist.

4.14. All orders for medications in the following categories shall automatically expire as follows:

4.14.1. Vancomycin empiric therapy expires forty-eight (48) hours from the initial order

4.14.2. Orders for all other medications, including controlled and non-controlled substances, expire in thirty (30) calendar days.

4.15. Pharmacists may modify the duration of an order to assure appropriate length of therapy with respect to safety, patient needs, or hospital policy. Pharmacists should modify any critical medication order that is due to expire during the night to continue until the prescriber can be notified and a new order entered if the medication should be continued.

4.16. There shall be a documented diagnosis, condition, or indication in the medical record for each medication ordered.

Adverse medication reactions shall be reported by clinicians, including Medical/Dental staff members, to the pharmacy.

The Pharmacy and Therapeutics Committee of the Medical/Dental Staff is delegated the responsibility of restricting the use of a specific medication or class of medications and expectations for use, either entirely or for use only in stated conditions or for use only on consent of a specified expert. The Medical Executive Committee has a right to review the recommended restriction of medications as developed by the Pharmacy and Therapeutics Committee on an ongoing basis.

SECTION 5. Consultation

5.1. A consultation is defined as an evaluation of a patient provided at the request of an attending physician/dentist, Resident, Fellow, or APP to either recommend care for a specific patient's condition or to determine whether to accept responsibility for ongoing management of the patient's care. Any consultation request, whether in-person or by telephone, that seeks medical advice about a **specific patient** is considered a consultation and therefore must be documented in the medical record in the timeframe as described below in Section 5.5.

5.1.1. The following reports and/or forums are excluded from the definition of a consult and do not need to be documented as a consultation: preliminary readings from radiology or pathology, pathology reports, radiology reports, test interpretation reports, tumor board and other patient care conferences where recommendations are communicated, and/or factual information about treatment (i.e. antibiotic choice or medication information) that is not related to a specific patient.

5.2 The attending physician/dentist, Resident, Fellow, or APP is responsible for requesting consultation when indicated, calling the appropriate on call consultant, and placing an order for the consult in the medical record. The requesting attending physician/dentist, Resident, Fellow, or APP shall supply the consultant with all relevant information regarding the patient and communicate the relative urgency and desired timeframe for completion of the consultation. The consultant shall communicate any anticipated delays in completion of the consultation. The primary responsibility for the patient shall remain with the requesting physician/dentist, unless notice of transfer of care is documented in the medical record.

5.3. Once the consultation is completed, the consultant and the requesting attending physician/dentist, Resident, Fellow, or APP shall discuss the final recommendation. Attending physician/dentist to attending physician/dentist verbal communication is preferred. A consult is considered complete when advice about a specific patient is given by phone or when the patient has been examined by the consultant and a recommendation has been communicated to the requesting attending physician/dentist, Resident, Fellow or APP. This is when the documentation timeframe requirement as defined below in Section 5.5 will begin.

5.4 Consultation reports shall show evidence that the consultant has provided sufficient documentation to address the request from the requesting attending physician/dentist, Resident, Fellow, or APP. A limited statement such as "I concur" generally would not constitute an adequate consultation report. Except in emergency situations, as verified in the medical record, a

consultation relative to an operative or potentially hazardous procedure shall be recorded prior to the surgery or procedure being performed.

5.5 It is highly recommended that a brief note containing the consultant's recommendation(s) be placed in the medical record as soon as possible but not later than twenty-four (24) hours of completing the consultation. If further documentation is needed that is not contained in the brief note, the consulting service shall enter a consultation note within 48 hours of completing the consultation as defined above in Section 5.3.

5.6 *Consult requests from the Emergency Department (ED)*
When a consult is needed in the ED, the requesting ED attending physician, Resident, Fellow or APP must clarify if the phone call is for general advice or for advice on a **specific patient**. If the request meets the definition for a consult as defined above in Section 5.1, a consult order must be entered by the requesting ED attending physician/Resident, Fellow or APP. The requesting ED attending physician/Resident, Fellow or APP shall supply the consultant with all relevant information regarding the patient and communicate (i.) if the patient needs to be seen in person or if the consultant's recommendations can be provided by telephone, and (ii.) the relative urgency and desired timeframe for completion of the consult.

5.6.1. The consultant shall communicate the anticipated timeframe for completion of the consultation. Disagreements regarding relative urgency, desired timeframe, and the need for an in-person consultation shall be resolved by attending to attending physician discussion. If the disagreement cannot be resolved, then the ED attending physician who has seen and evaluated the patient shall make the final determination.

5.6.2. The primary responsibility for the patient shall remain with the requesting ED attending physician, Resident, Fellow or APP unless notice of transfer of care is documented in the medical record. The consultant (or Resident/Fellow/APP designee) shall communicate the recommendations verbally to the requesting ED attending physician, Resident, Fellow or APP. Attending to attending physician communication is preferred.

5.6.3. A brief consult note shall be placed by the consultant (or Resident/Fellow/APP designee) in the medical record as soon as possible or within **12 hours** of completion of the consult defined above in Section 5.3.

5.6.4. If the ED attending physician requests the consultant to see the patient in person with a potential emergency medical condition, the consultant will appear within a reasonable time (which is expected not to exceed thirty (30) minutes), unless there are circumstances beyond the physician's control (such as, currently operating on another patient, is responding to call coverage at

another hospital, or is delayed due to extreme weather condition, personal illness, or transportation failures).

SECTION 6. General Requirements

6.1. Written authorization of the patient, parent, or other legally authorized representative is required for release of medical information to individuals not otherwise authorized by law to receive this information.

6.2. General consent for treatment covers evaluation and routine medical, nursing, and other patient care, treatment and procedures that do not require informed consent (i.e. procedures and treatment that do not have risks, hazards, or alternative treatments that a reasonable person would want to know prior to giving consent). General consent must be obtained from a patient or the patient's parent or legal representative before medical services/care can be provided at Children's Dallas or as otherwise outlined in the Children's Dallas Disclosure and Informed Consent Policy (hospital policy). General consent is valid and remains in effect during the patient's hospital admission for inpatients and for one year from the date of signature for outpatients.

6.3. In addition to general consent obtained by Children's Dallas at the time of the patient's admission, in accordance with the process outlined in the hospital policy, informed consent is required for procedures and treatment that have benefits, risks, side effects and alternative treatments that a reasonable person would want to know prior to giving consent. Informed consent shall be obtained and signed by the physician/dentist performing the procedure or treatment ("Responsible Physician/Dentist") or by a qualified designee (i.e. associate physician, resident, fellow or APP) who has the clinical knowledge and/or expertise for the procedure or treatment being performed to adequately provide information for informed consent and who has been designated by the Responsible Physician/Dentist to provide such information. The "Responsible Physician/Dentist" has the full responsibility for the procedure or treatment being provided to the patient. The Responsible Physician/Dentist of record is responsible for verifying that informed consent has been properly obtained.

6.4. Exceptions to obtaining consent may be made for emergency conditions, life-threatening situations, or suspicion of abuse, as outlined in hospital policy. The attending physician/dentist, who is ultimately responsible for the care of the patient, shall be responsible for determining, and subsequently documenting, whether the patient has what reasonably appears to be an emergency, life-threatening injury or illness; care shall not be delayed if the attending physician/dentist deems emergent care is needed

and there is either insufficient time to obtain consent and/or the patient's parent or legal representative is not present and cannot be contacted immediately.

6.5. Telephone consent may be obtained when the patient's parent or legal representative is not available in person to provide written consent. Documentation of telephone consent into the medical record shall be made in accordance with hospital policy.

6.6. If consent covers a series of like procedures that may be performed over a period of days, the consent form shall indicate the number of procedures and time frame for which the consent is in effect.

6.7. If a patient's condition changes or the risks associated with the procedure change a new consent form must be executed.

6.8. If a written consent was obtained greater than sixty (60) calendar days prior to the scheduled procedure or treatment, the Responsible Physician/Dentist must:

- Obtain a new written consent; or
- If the patient's parent or legal representative is the same individual who previously signed the consent form and there are no changes to the patient's condition noted in the updated history and physical, re-sign and re-date the consent form and have the parent/legal representative re-sign and re-date the consent form after review and discussion and have the re-signed/re-dated signatures witnessed.

6.9. Informed consent must be obtained for research as required by the Institutional Review Board ("IRB") and Children's Dallas policy for informed consent for research.

6.10. Each patient shall be assigned an attending physician/dentist. A patient or the patient's parent or legal representative may request a change of the assigned attending physician or dentist. Such a request will be honored to the extent possible, after consideration of the patient's medical care needs. When such a change occurs, all previous orders for treatment shall be canceled and new orders will be required.

6.10.1. The attending physician/dentist can delegate to an APP, under the supervision of an attending physician/dentist.

6.10.2. The patient shall have the right to request to be seen by the attending physician/dentist instead of, or in addition to, the APP.

6.11. When necessary and in the absence of the regular attending physician/ dentist any member of the Medical/Dental Staff with clinical privileges may be requested by the Division Director to attend a colleague's patient. The requested Medical/Dental Staff member shall be expected to show the same consideration he or she would wish to have shown to one of his or her patients under similar circumstances.

6.12. All physicians/dentists, APRNs and PAs shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements.

6.13. Clinical laboratory tests shall be done by Children's Dallas or in an outside (reference) laboratory recommended by the Division Director of Pathology or designee and approved by the Medical Executive Committee. The Division Director of Pathology or designee shall take reasonable steps to assure itself that any outside laboratory sources, from which test reports are used as the official Children's Dallas medical record report are in compliance with applicable state, federal and Joint Commission requirements.

6.14. The Radiology Division shall provide authenticated reports for all radiologic examinations performed under the radiologist's supervision at Children's Dallas and, when requested, for review of CT and MRI examinations performed outside of Children's Dallas and its affiliates. Otherwise, the attending physician/dentist or authorized licensed practitioner may record his/her own interpretation in the history or progress note section of the medical record (to include dental images, non-radiologist fluoroscopy, and speech studies). When special cardiovascular radiologic procedures can be properly interpreted only with the findings and observations of the authorized physician/dentist (e.g., cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.

6.15. When surgical procedures or medical therapy are to be performed based on tissue examined at another institution or laboratory, the admitting attending physician/ dentist shall be responsible for furnishing a copy of the pathology report from the outside institution or laboratory for the patient's medical record. When possible, the diagnostic slides from the referring institution or laboratory shall be reviewed by a Children's Dallas staff pathologist, and a report shall be issued for the patient's medical record.

6.16. The ordering of any baseline admission testing (e.g., laboratory, imaging, electrocardiography, etc.) shall be the responsibility of the attending

physician/dentist (or authorized designee) on an individual-patient basis. For surgical cases, this shall be done, as indicated, in conjunction with the anesthesia division.

6.17. Physicians/dentists, APRNs or PAs requesting diagnostic examinations by a pathologist or radiologist shall provide, in the written request, all relevant information available, so as to assist in the determination of an accurate diagnosis/impression.

6.18. Human materials removed at surgery (e.g., surgical specimens) or autopsy (excluding teeth and those specimens exempt from pathological examination as defined below in Section 2.1.5.1) shall be disposed of in a manner commensurate with the Texas Administrative Code for Disposition of Special Waste. Specimens removed during the procedure shall be sent to the Pathologist who shall make necessary examinations to arrive at diagnosis. The Pathologist's written report of this examination and conclusions shall be included in the patient's medical record. Specimens (other than teeth and certain non-human foreign bodies, such as coins or jewelry) shall not be returned to the patient or patient's family except in specific circumstances as authorized by law and Children's Dallas policy and approved by the legal department.

6.18.1. The following specimens may be exempt from microscopic and macroscopic examination (at the surgeon's or proceduralist's discretion) and will be properly disposed in a biohazardous waste bag:

- Extraocular muscles from strabismus repairs
- Foreign bodies
- Foreskins if grossly normal
- Nail Plates (fingernails and toenails that are grossly normal)
- Teeth
- Tonsils
- Adenoids
- Bone and cartilage from reconstructive procedures and osteotomies
- Prosthetic devices and hardware
- Orthodontic appliances
- Surgical hardware
- Skin and skin scars from cosmetic procedures
- Omentum from Dialysis placement
- Hyperplastic gingival tissue for which there is a clear etiology
- Gingival tissue removed for gingival plastic procedures
- Calculi
- Supernumerary digits

6.19. In the event of a patient death at Children's Dallas, the deceased shall be pronounced dead by a physician. The body shall not be released until a record of the patient's death is completed and placed in the medical record of the deceased.

6.20. It shall be the responsibility of the attending physician, coordinated as needed with other members of the Medical Staff/Fellows/Residents, to inform every family of the option for an autopsy, and to attempt to secure an autopsy in all cases including, but not limited to, cases of unusual death and those of educational interest. It is also the responsibility of the attending physician to report cases of medical legal interest to the appropriate authorities. If an autopsy is obtained, it is the responsibility of the attending physician to communicate the results of the autopsy and the implications of the findings with the child's family. Autopsies shall be performed following appropriate written consent and in accordance with state law. All autopsies shall be performed by a Children's Dallas pathologist, unless by law the autopsy comes under the jurisdiction of the Medical Examiner/Coroner, or the family requests otherwise.

6.20.1. The attending physician will be notified (via paging system or phone call) of any autopsies prior to the start of the autopsy; however, the autopsy will not be delayed if the attending physician is unavailable.

6.21. All physicians/dentists and APPs shall foster a strong culture of safety by participating in quality, safety, and performance improvement initiatives upon request as defined by the code of conduct.

6.22. Transfusion of blood and blood components shall be done in accordance with hospital and laboratory policies and procedures, in accordance with recommendations of Children's Dallas Tissue and Transfusion Utilization Committee.

6.23. Pathology slides are the property of Children's Dallas and may be lent to other hospitals, physicians/dentists/APPs, or research institutions for valid reasons and upon approval of a Children's Dallas pathologist.

6.24. All physicians/dentists and APPs shall be responsible for knowing their obligations in the event of a disaster or other emergency situation (i.e., fire, tornado, bomb threat, etc.) and shall report accordingly. They shall participate in emergency management/fire prevention drills as required.

6.25. Oxygen and respiratory therapy shall be administered in accordance with the attending physician's, dentist's, or APP's order or in accordance with established policy and protocol approved by the Medical/Dental Staff through its designated mechanism. In cases where the duration of treatment is not specified or is stated indefinitely, the treatment shall be discontinued as per policies of the Respiratory Care Department unless new orders are documented; however, prior to discontinuing the treatment, the nurse or therapist shall notify the attending physician, dentist, or APP and confirm that the treatment should be discontinued.

6.26. All respiratory therapy orders for critical care patients must be reviewed and documented daily. All oxygen and respiratory therapy orders on non-critical care patients shall be reviewed at least every seventy-two (72) hours.

6.27. Designated qualified members of the Medical/Dental Staff present at Children's Dallas shall respond to cardiopulmonary resuscitation codes in accordance with Children's Dallas policy.

6.28. Any member of the Medical/Dental Staff who has reason to find fault with an employee of Children's Dallas, shall report the deficiency to the relevant supervisor or department director immediately and if needed, follow the appropriate escalation path. In no case shall the Medical/Dental Staff member take it upon him or herself to discipline an employee. In cases where the patient may suffer harm if action is not taken immediately, the physician/dentist may require that the employee relinquish care of his or her patient(s) until the matter is investigated.

6.29. The Infection Prevention and Control Committee, through its chairperson or members, has the authority to institute any appropriate control measures or studies when it is reasonably believed that a danger to patients, visitors, or personnel exists. This authority includes placing a patient under isolation precautions even though the attending physician/dentist/APP may not believe such precautions are necessary.

6.30. All inpatients shall be visited by their attending physician/dentist within twenty-four (24) hours of admission and once every calendar day thereafter; this visit shall be documented by entering a note that same day in the medical record (see section 2.3). If this requirement cannot be fulfilled, the attending physician/dentist shall arrange for another qualified member of the Medical/Dental Staff with clinical privileges to attend the patient, and the nursing staff shall be notified of the name of the physician/dentist who shall be responsible in the interim.

6.31. Patients in need of behavioral restraint/seclusion shall be restrained/secluded for the protection of self or others in compliance with applicable laws. When use of behavioral restraints/seclusion is indicated, justification for such use and a time-limited order by the physician noting both start and end times shall be present. The time-limited order should be no longer than four (4) hours for patients eighteen years of age and older, two (2) hours for patients aged nine (9) to eighteen (18) years, and one (1) hour for patients under the age of nine (9) years. The time-limited order must be signed and an assessment of the patient made by a licensed physician within one (1) hour of the application of behavioral restraint/seclusion. Other requirements of Children's Dallas restraint/seclusion policy and procedure shall also be met.

6.32. When a life-threatening situation develops requiring the administration of blood or blood products for survival, even if the patient, parent or other authorized party objects due to religious reasons or other reasons, the attending physician, with the assistance of Children's Dallas, shall attempt to obtain the necessary legal means to administer blood or blood products to sustain life.

6.33. When any professional person of the care team has any reason to doubt or question the care provided to a patient or believes that consultation is needed and has not been obtained or requested, he or she may call this to the attention of his/her supervisor. The supervisor shall follow Children's Dallas escalation policy. This concern should be brought to the attention of the Division Director to which the physician/dentist is assigned or, if the Division Director is unavailable, to the Chief Medical Officer Dallas or JPE Chief Medical Officer. When circumstances justify action, the Division Director, Chief Medical Officer Dallas or the JPE Chief Medical Officer may request a consultation.

6.34. Physician, dentist, and APP performance should comply with performance measurement initiatives, national patient safety goals and other national and institutional practice standards.

SECTION 7. Emergency Services

7.1. A medical screening examination ("MSE") may be performed by a qualified physician, APRN, or PA.

7.2. The emergency medical record shall be made a part of the patient's permanent medical record.

7.3. Each emergency medical record shall be signed by the physician/dentist/APP in attendance who is responsible for its accuracy.

7.4. There shall be a triage system to identify patients requiring emergent/urgent care.

7.5. The disposition of each patient shall be a physician responsibility. This responsibility can be delegated to an APP through established collaborative practice agreements.

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

7.7. Procedures requiring general anesthesia shall be performed in the surgical suite instead of the Emergency Department except when emergency circumstances dictate. Examples for when general anesthesia can be administered in the Emergency Department include, but are not limited to, initiation of ECMO, emergency thoracotomy, and emergency intracranial trephination.

7.8. In an emergency when a patient requires admission to an inpatient unit, the physician/dentist or designee shall contact the Bed Control Coordinator to ascertain whether there is an available bed.

7.9. When a patient requiring admission on an emergency basis does not have a primary care physician, the patient shall be admitted to the appropriate medical or surgical service.

7.10. When a patient requiring admission on an emergency basis has a primary care physician, the primary care physician shall be notified regarding both the patient's admission and the service to which the patient was admitted. If the primary care physician is an attending Medical/Dental Staff member with clinical privileges, the primary care physician has the option to admit to his/her own service or to another medical staff service.

7.11. At least one Pediatric Emergency Medicine attending physician must be present in the Emergency Department at all times. If the attending physician must briefly step away, coverage for emergency situations will be provided by a Qualified Medical Personnel (Resident, Fellow or APP).

7.12. Patients, parents, or other authorized parties, on leaving the Emergency Department following evaluation and/or treatment, shall be given written follow-up instructions, which shall have been signed by the patient, parent,

or other authorized party, stating that the patient, parent, or other authorized party has received and understands the instructions provided by the attending physician/dentist or Emergency Department registered nurse. Any language barrier shall be compensated for through the use of an interpreter, by instructions written in the patient's, parents, or other authorized party's language, or by another acceptable system, and this shall be noted on the instruction sheet.

7.13. The emergency medical record for each patient treated shall include: the time of the patient's arrival; the means of arrival and by whom transported; any available details of the emergency care rendered to the patient prior to arrival at Children's Dallas; whether (and, if relevant, when and for what) the patient visited any Emergency Department previously; acknowledgment of any ordered test results; and the conclusions at termination of treatment (including final disposition, condition on discharge, and any instructions given to the patient on discharge for follow-up care).

7.14. Specialist coverage shall be provided by Medical/Dental Staff members with appropriate clinical privileges in accordance with an established roster or on-call system as required by Children's Dallas. When a transportable patient requires Medical/Dental Staff consultation/treatment not available at Children's Dallas, the patient shall be transferred to an appropriate facility as soon as possible after being stabilized for transfer within the capability and/or capacity of the Emergency Department, subject to compliance with the hospital's transfer policy, and subject to having first obtained acceptance by that facility through a physician and the administrator or designee of that facility.

SECTION 8. Obtaining Organs and Tissues for Transplantation

8.1. Consent for the removal of organs and/or tissues for the purpose of transplantation shall be obtained from the patient, parent, or other authorized party by a representative of Southwest Transplant Alliance Organ and/or Tissue Donation for Transplantation Tissue and Organ Donor at UTSW using their appropriate consent form.

8.2. The diagnosis of the death of the patient shall be made by the patient's attending physician using the criteria he or she deems appropriate in his/her clinical judgment according to Children's Dallas policies. The patient's physician may delegate this responsibility to another physician provided he or she is a member of the current Medical Staff and is not a member of the transplantation team.

8.3. In all instances where brain death is thought to precede the cessation of cardiopulmonary function, the patient shall be evaluated by two (2) attending physicians to determine if the brain death criteria have been met. Compliance with these criteria shall be necessary in order for the patient to be considered for organ and/or tissue donation via brain death.

8.4. In instances where cessation of cardiopulmonary function will be utilized to pronounce patient death, prior to organ and tissue donation, hospital policies will be followed for the donation of the patient's organ and/or tissue following cardiac death. All organ and/or tissue donation criteria will be met and the documentation for the organ and/or tissue procurement will be done in accordance with the current applicable policies.

8.5. All organ and/or tissue procurement documentation and criteria must be done so under the requirements established and outlined in the current Brain Death policy and Organ and Tissue Donation After Cardiac Death policy.

8.6. Physicians involved with the procurement of organs and/or tissues for transplantation shall not be involved with the decision to discontinue life support systems or the declaration of death.

8.7. If an autopsy is also requested, discussion of the planned organ and/or tissue procurement by the transplantation team with the attending pathologist should occur prior to procuring any organs and/or tissues, so that the autopsy is not compromised.

SECTION 9. <u>Surgical Care</u>

For purposes of Section 9, "responsible physician/dentist" shall have the same meaning as defined above in subsection 6.3.

9.1 Each physician/dentist/APP working in the Operating Room must abide by the policies of the Operating Room.

9.2 All requirements in the "Medical Records" section of these rules and regulations shall apply in the care of surgical patients, particularly with reference to the history and physical examination, recording of preoperative diagnosis, completion of operative reports, and all sedation/anesthesia-related requirements. The requirements for informed consent also apply.

9.3 The responsible physician/dentist/APP shall be present at Children's Dallas before the patient is brought into the operating room.

9.4 The responsible physician/dentist/APP must be on the Children's Dallas hospital premises and ready to begin surgery/procedure prior to that patient being brought to the operating room/procedure room. The responsible physician/dentist/APP must be present in the operating/procedure room within thirty (30) minutes after arrival of the patient into the operating room/procedure room.

9.5 The responsible physician/dentist must be present in the operating room for all key portions of the procedure (excluding auditory brainstem response (ABR), peripherally inserted central catheter (PICC) line placement and cast application).

9.6 All patients receiving general, epidural, spinal anesthesia, or sedation by Anesthesiology shall go to a Post Anesthesia Care Unit ("PACU"), directly to a critical care unit, or other designated recovery area. Patients receiving only local anesthesia may be returned directly to their room or may go to the PACU or other designated recovery area at the request of the responsible physician/dentist/APP.

9.7 All patients must have a discharge order prior to transfer from the PACU or other area of the hospital where anesthesia is being administered ("procedure room"). The discharge order must be entered in the medical record by the primary responsible attending physician/dentist/APP or designee for the procedure, which preceded PACU or other designated recovery area. In the case of patients receiving only anesthesia care, the responsible attending anesthesiologist must enter the discharge order (Also refer to sections Anesthesia - 10.9 and Sedation - 11.4).

9.8 Any day surgery patient (outpatient) who has received anesthesia (other than local or topical anesthesia), and has remained in the Phase II recovery area of the PACU or other designated recovery area for two (2) hours or longer after leaving the Phase I recovery area of the PACU or other designated recovery area shall be evaluated by both an anesthesia care team member (attending anesthesiologist, Fellow, APRN, PA, CAA or CRNA) and a member of the operative/procedural care team at the time of discharge. Disposition of the patient at this point is the responsibility of, and must be a joint decision between, the attending surgeon/proceduralist and attending anesthesiologist.

9.9 Day surgical procedures are limited to those surgical procedures approved as such by the Medical/Dental Staff and Administration.

9.10 Day surgery shall be included in surgical case evaluations performed by the divisions and, as indicated, by the Surgery Department.

9.11 Physicians/dentists/APPs performing surgical procedures shall report all complications to the respective Division Director.

9.12 Operation scheduling is done through the operating room and according to a block scheduling system.

9.13 Patients shall be transported from the operating room or procedure room to the PACU or other designated recovery area by an attending anesthesiologist, Fellow, Resident, CAA, CRNA or physician prescribing sedation.

9.14 All responsible physicians/dentists/APPs shall abide by the Operating Room policy regarding confirmation of the identity of the patient; the proposed procedure; the site, side and level to be operated upon; and that the pre-operative anesthesia fasting guideline("NPO" nils per os) status has been maintained.

9.15 All responsible physicians/dentists/APPs with operating room privileges must cooperate with the current operating room protocol for needle, sponge, and instrument counts.

SECTION 10. Anesthesia

10.1. An anesthesiologist must complete or co-sign the pre-anesthesia evaluation within 48 hours prior to surgery or a procedure, and the evaluation must include at a minimum: contemplated choice of anesthesia for the procedure; drug history; review of the patient's physical status (using the classification of the American Society of Anesthesiologists); history of allergies; previous anesthetic experiences; and an anesthetic risk evaluation.

10.2 The anesthesiologist or anesthesia care team ("ACT") member shall record in the medical record evidence of a pre-anesthesia check of the anesthesia machine and monitoring equipment. The anesthesiologist shall also document his or her assessment of the patient immediately prior to the induction of anesthesia. The anesthesiologist or ACT member shall also record all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood and blood components.

10.3 The responsible anesthesiologist or ACT member, (Fellow, Resident, CRNA, or CAA), shall be in constant attendance during the entire procedure. Following the procedure, the anesthesiologist, Resident, Fellow, CRNA or CAA shall be available as long as required by the patient's

condition and until the responsibility for proper patient care has been assumed by another qualified physician.

10.4. An attending anesthesiologist must be physically present during induction, emergence and all critical portions of the case and immediately available from the time preoperative medication is administered until the patient is suitable for discharge from the PACU or other designated recovery area, or the patient's care has been transferred to another suitably qualified physician. An attending anesthesiologist who is working with another Anesthesia Care Team member (CRNA, CAA, Fellow, Resident) is providing anesthetic care by medical direction. A Medically Directing Anesthesiologist is considered "immediately available" if he/she is located within the same area as the Anesthesia Care Team Member, and not occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed. The Medically Directing Anesthesiologist is in physical proximity that allows him/her to re-establish direct contact with the patient to meet medical needs and any urgent or emergent clinical problems. These responsibilities may also be met through coordination among attending Anesthesiologists working together at Children's Dallas. There will be an identifiable Medically Directing Anesthesiologist at all times in the anesthetic care of each patient.

10.5. The anesthesiologist shall review all pertinent laboratory work.

10.6. An emergency call system shall be maintained by the Division of Anesthesiology to allow for adequate coverage for the services of an anesthesiologist.

10.7. Safety policies and procedures regarding the administration of anesthesia, maintenance of machines, techniques and methods of delivery, and safety hazards shall be developed and periodically reviewed by the Division of Anesthesiology. Members of the Medical/Dental Staff and all hospital employees shall comply with these safety policies and procedures.

10.8. The Anesthesiologist in Chief or his/her designee is responsible for medical direction of the PACU and any designated recovery area.

10.9. All patients must have a discharge order prior to the transfer from the PACU or other designated recovery area, and a post-anesthesia evaluation note completed within forty-eight (48) hours; for outpatients, this note will be completed prior to discharge. The 48-hour timeframe begins at the point the patient is moved into the designated recovery area. When a patient has received care from the Anesthesiology Division, the discharge order may come from an attending anesthesiologist, Fellow, CAA or CRNA. Refer to Section 9.7 above

for discharge order requirements for a patient not receiving care from the Anesthesiology Division.

10.10. Disposition of a patient from the Operating Room or Procedure Room is the responsibility of and must be a joint decision between the responsible physician/dentist/APP and the anesthesiologist.

SECTION 11. Sedation

11.1. A pre-sedation evaluation of the patient must be documented in the medical record prior to any procedure in which moderate/deep sedation/analgesia is to be administered. This evaluation shall include reference to the choice of sedation, the patient's allergies and any previous medication, drug history, other anesthesia/sedation experiences, any potential anesthetic/sedation problems, and the anticipated location for post-sedation recovery. The patient's physical status shall be categorized using the classification of the American Society of Anesthesiologists.

11.2. The individual administering moderate sedation must be capable of managing inadvertent deep sedation, which means that he or she must be competent in managing a compromised airway including provision of adequate oxygenation and ventilation. The sedation credentialed licensed independent practitioner shall re-assess the patient immediately prior to induction of moderate sedation.

11.3. The physician/dentist administering deep sedation must be capable of managing inadvertent general anesthesia; which means that he or she must be competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation. The physician/dentist shall re-assess the patient immediately prior to induction of deep sedation.

11.4. There shall be documentation in the medical record that the discharge of any patient from the PACU or other designated recovery area has met the criteria as outlined in section 9.7 above.

11.5. Medical record information from a post-sedation recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area, the vital signs, pain intensity and quality, medications administered, and, when such are in use, the status of infusions, surgical dressings, tubes, catheters, and drains.

SECTION 12. Ambulatory Services

12.1. The Medical/Dental Staff shall provide medical/dental diagnosis and treatment in the ambulatory patient care areas. This responsibility can be delegated to an APP through an established collaborative practice agreement. This shall be in accordance with Children's Dallas basic plan for delivery of such services, including the delineation of clinical privileges for all attending physicians and dentists who render ambulatory patient care. Residents and Fellows may provide care to patients under the direct supervision of an attending physician or dentist.

12.2. An appropriate medical record shall be maintained for every patient receiving ambulatory care and shall be incorporated into the patient's permanent medical record. The record of ambulatory care must include the following:

12.2.1. Adequate patient demographic data;

12.2.2. Pertinent medical and surgical history;

12.2.3. Description of significant clinical, laboratory, and imaging findings;

12.2.4. Diagnosis;

12.2.5. Treatment provided;

12.2.6. Condition of the patient on discharge or transfer;

12.2.7. Any instruction given to the patient and/or family relating to necessary follow-up care; and

12.2.8. Reconciliation of medication, including known allergic and other adverse drug reactions, known long-term medications prescribed for or used by the patient including over-the-counter and herbal treatments.

SECTION 13. Critical Care Units

13.1. Patients may be referred for admission to the critical care units by any member of the Medical/Dental Staff with clinical privileges on a priority basis. For any patient admitted to the critical care unit, consultation with the Intensive Care Unit intensivist shall be required throughout the patient's admission.

13.2 Beds in the critical care units shall be reserved for the care of critically ill patients who have the potential to recover from their acute critical illness by active intervention in an intensive care unit.

13.3 The attending physician is responsible for the care of the patient while in Pediatric Intensive Care Unit ("PICU") and also for the patient's discharge from the unit.

13.4 Approved criteria for admission to the critical care units shall be found in the policy "Admission/Discharge Criteria for Critical Care Units".

13.5 During times when the critical care units are full, the Medical Directors of the Critical Care Units shall review each patient's condition on a daily basis and shall have the authority to transfer a patient from the critical care unit to a general nursing unit if such transfer is medically indicated after notification of the patient's attending physician.

SECTION 14. Resident's Scope of Practice

14.1 A Resident's training shall occur in accordance with Accreditation Council on Graduate Medical Education (ACGME) Common Program Requirements. A Resident's eligibility and performance must also be consistent with UT Southwestern Graduate Medical Education policies and procedures.

14.2 Dental Residents must meet the qualifications for advanced education students as outlined in the Commission on Dental Accreditation Standards for advanced specialty education programs for their respective specialty.

14.3 The position of Resident shall involve a combination of supervised, progressively more complex, and independent patient evaluation and management function and formal educational activities. The competence of the Resident shall be evaluated on a regular basis by the Program Director.

14.4 The Resident shall provide care commensurate with his/her level of advancement and competence under the general supervision of appropriately privileged attending teaching physicians/dentists. This includes:

14.4.1. Participation in safe, effective and compassionate patient care;

14.4.2. Development of an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical/dental education;

14.4.3. Utilization, when appropriate, of institutional clinical practice guidelines;

14.4.4. Participation in the educational activities of the training program and, as appropriate, responsibility for teaching and supervising other Residents and students;

14.4.5. Participation in institutional orientation and education programs;

14.4.6. Participation in institutional committees and councils to which the Resident is appointed or invited;

14.4.7. Performance of these duties in accordance with the established practices, procedures, and policies of Children's Dallas, and those of its programs, clinical divisions, and other institutions to which the Resident is assigned, including, among other duties, state licensure requirements for physicians/dentists in training, as applicable;

14.4.8. Compliance with the guidelines of care as defined by the Resident's individual training program; and

14.4.9. Compliance with Children's Dallas policies and procedures, Rules and Regulations, contracts, and institutional agreements.

SECTION 15. Faculty Permit Physicians Scope of Practice

15.1. Physicians who hold faculty permits must meet the qualifications for Active or Associate Staff category membership of the Medical/Dental staff. They may exercise the Active or Associate Staff Category prerogatives outlined in the Medical/Dental Staff Bylaws except as limited by this Section.

15.2. The practice of medicine by faculty permit physicians and their duties and responsibilities shall be limited to the teaching confines of UT Southwestern as required by the Texas Medical Board. They may participate in the clinical, patient care, and teaching activities of UT Southwestern at Children's Dallas.

15.3. Faculty permit physicians may write orders for or prescribe controlled substances for patients of Children's Dallas as allowed under the hospital's controlled substance registration.

SECTION 16. Adoption, Review, and Amendments of the Rules and Regulations

16.1. The Medical/Dental Staff, through its designee, shall periodically review the Rules and Regulations, and the results of this review shall be presented to the Medical Executive Committee. Any revisions based on this review shall be made in accordance with the process outlined in the Medical/Dental Staff Bylaws.

16.2. Rules and Regulations may be adopted, repealed, or amended by a majority vote of the Medical Executive Committee and the Board, in accordance with the process outlined in the Medical/Dental Staff Bylaws.

16.3. Neither the Medical/Dental Staff nor the Board of Directors may unilaterally amend these Rules and Regulations of the Medical/Dental Staff.

ADOPTED BY THE BOARD OF DIRECTORS ON AFTER RECEIPT OF A RECOMMENDATION FROM THE MEDICAL EXECUTIVE COMMITTEE.