# Our Children's House

# RULES

# AND

# REGULATIONS

# OF THE

# MEDICAL STAFF

# TABLE OF CONTENTS

Section 1. Admission, Transfer and Discharge of Patients ..... 3-4

Section 2. Medical Records ..... 5-10
- 2.1. General Medical Record Practices ..... 5-7
- 2.2. History and Physical ..... 7-8
- 2.3. Progress Notes ..... 8
- 2.4. Discharge Summary ..... 8-9
- 2.5. Incomplete/Delinquent Medical Records ..... 9
- 2.6. Automatic Suspension and Relinquishment of Privileges ..... 9-10

Section 3. Orders ..... 10-11

Section 4. Medication Management ..... 11-13

Section 5. Consultation ..... 13-14

Section 6. General Requirements ..... 14-19

Section 7. Ambulatory Services ..... 19-20

Section 8. Resident's Scope of Practice ..... 20-21

Section 9. Faculty Permit Physicians Scope of Practice ..... 21

Section 10. Adoption, Review and Amendments of the Rules and Regulations ..... 21-22

## SECTION 1. Admission, Transfer and Discharge of Patients

1.1. A patient may be admitted to Our Children's House only by a member of the Medical Staff having admitting privileges. A member of the Medical Staff may, in the course of care for a patient, request that the patient be admitted to a different medical service. In that case, the referring Medical 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 Our Children's House 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 physician responsibilities between two providers, the accepting provider is responsible for confirming the attending physician designation within the electronic medical record has been changed.

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

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

1.6. Except as otherwise provided in Our Children's House policies, no patient shall be transferred within Our Children's House without the approval of the attending physician, 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 Our Children's House 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 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, or MD) who will provide the findings of that assessment to the patient's treating physician. The patient's treating physician 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 consultation 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 Our Children's House 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 nurse ("APN"), or physician assistant ("PA") authorized by the attending physician. If a patient leaves Our Children's House 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 AMA from Our Children's House 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 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 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 Our Children's House;

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

1.13.4. Adhere to Our Children's House admitting policies and procedures.

## SECTION 2. Medical Records

### 2.1. General Medical Record Practices

2.1.1. The attending physician 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 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; procedure reports; consultations; condition on discharge; discharge summary; and final diagnosis.

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 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. 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.

2.1.3. The medical record, including but not limited to imaging files, pathology slides and test results, is the property of Our Children's House and shall not be removed from Our Children's House premises without a release from the Health Information Management Department, except as outlined in Section 6.25. Unauthorized removal of medical records from Our Children's House by any person is grounds for suspension of the person for a period to be determined by the Medical Executive Committee of the Medical Staff.

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

2.1.5. Subject to applicable laws, access to all medical records of all patients shall be afforded to members of the Medical 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.

2.1.6. Medical records shall not be permanently filed until completed by the attending medical staff member or ordered to be filed by the Health Electronic Record/Health Information Management Committee of the Medical Staff. An incomplete record will not ordinarily be filed if the attending physician is still a member of the Medical Staff or holds clinical privileges at Our Children's House. No physician 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 who is responsible for completing the record. Any physician whose privileges are suspended or relinquished per the Medical Staff Bylaws and/or the Medical Staff Rules and Regulations for delinquent records or who resigns from the Medical Staff without adequately completing all medical records will not be reinstated or allowed to reapply for Medical Staff membership until such records are satisfactorily completed.

2.1.7. Physicians 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.

2.1.8. 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 Our Children's House policy, by the approved practitioner.

2.1.9. 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 Our Children's House policy. The attending physician must countersign all histories and physical examinations, discharge summaries, consultations, radiology reports and

pathology reports written by Residents and Fellows or APPs practicing in an inpatient setting.

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

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

2.1.12. Any use of handheld mobile devices, smart phones and/or tablets must use Our Children's House's 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 Staff shall be responsible for the medical care and treatment of each patient at Our Children's House. All patients shall have a history and physical examination completed and documented in the medical record by a physician member of the Medical Staff with clinical privileges or licensed individual approved for such privileges based on demonstrated clinical competence.

2.2.3. 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.

2.2.4. 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:

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

2.2.6. 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:

2.2.7. 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 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 Our Children's House Informed Consent Policy and sign the consent form.

2.2.8. 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.

2.2.9. For APPs practicing in an ambulatory clinic setting, 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 documented by the attending physician at least daily on all patients. 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. Discharge Summary

2.4.1. A discharge summary shall be documented or dictated 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 Our Children's House policy, by the attending physician.

2.4.2. 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. Incomplete/Delinquent Medical Records

2.5.1. The patient's inpatient 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. The outpatient records shall be completed contemporaneously with the patient's visit.

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

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

## 2.6. Automatic Suspension and Relinquishment of Privileges

2.6.1. The privileges of attending physicians or APPs shall be suspended if medical records become delinquent as defined in section 2.5. for greater than fourteen (14) calendar days.

2.6.2. Additionally, the Medical Executive Committee of the Medical Staff shall be notified promptly if any physician 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 Staff shall consider recommending to the Board that the attending physician'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 Staff and all privileges are deemed to have been voluntarily relinquished as outlined in the Medical Staff Bylaws.

*One suspension period shall not exceed four (4) consecutive weeks. If a physician remains on the suspension list for more than four (4) consecutive

weeks, the suspension period shall renew and count as an additional suspension period.

## SECTION 3. Orders

3.1. All patient orders shall be entered in the medical record by an Attending medical staff member, Resident, Fellow APP, or another provider who is providing care to the patient, and who, in accordance with Our Children's House policy; law and regulation; and Medical 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 Our Children's House policy, by the attending, Resident, Fellow, or APP. The attending, Resident, Fellow, APP, or another provider who is providing care to the patient, and who, in accordance with Our Children's House policy; law and regulation; and Medical 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 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 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 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 accepted only from members of the Medical Staff with clinical privileges and/or APPs, Residents and Fellows functioning within their scope of practice.

3.3. Any standing medical order, standing delegation order or medical protocol must 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 Our

Children's House's policy, applicable laws and regulations, and the Medical 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 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 Our Children's House 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.

3.6. 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 nursing unit or vice versa, or from outpatient to inpatient status.

3.7. Residents, Fellows, and APPs may document orders in the medical record.

## 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 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 member of the Medical 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 Our Children's House and be responsible for labeling and dispensing in accordance with the physician investigator's written orders.

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

4.6. It is the policy of Our Children's House that only medication dispensed through Our Children's House pharmacy may be used at Our Children's House. 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, 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 shall abide by medication requirements that have been delineated in other sections of these Rules and Regulations and applicable Medical Staff and Our Children's House 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 Service Chief to which the prescribing provider is assigned, the Chair of the Pharmacy & Therapeutics Committee or the Chief Clinical Officer 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.

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

4.18. The Pharmacy and Therapeutics Committee of the Medical 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. The attending physician, Resident, Fellow or APP is responsible for requesting consultation when indicated and for calling a qualified consultant. The attending physician (or authorized designee) shall provide written authorization to permit another physician to attend or examine the patient except when a *bona fide* emergency precludes this being done. The attending physician (or authorized designee) shall document in the medical record if the consultant is requested to document orders and/or assume aspects of care of the patient.

5.2. Any qualified physician or APP with clinical privileges at Our Children's House may be called by the physician or APP responsible for the patient to provide consultation within the consultant's area of approved clinical practice. The requesting provider shall communicate the relative urgency and desired timeframe for completion of the consultation. The consultant shall communicate any anticipated delays in completion of the consultation.

5.3. Although repeated consultations may be required and even though the consultant may undertake treatment in his/her phase of the patient's case, the primary responsibility for the patient shall remain with the original attending physician, unless notice of transfer is documented in the medical record.

5.4. Consultation reports shall show evidence that the consultant has provided sufficient documentation to address the request from the consulting provider. A limited statement such as "I concur" generally would not constitute an adequate consultation report. Except in emergency situations, so verified in the medical record, a consultation relative to a potentially hazardous procedure shall be recorded prior to the procedure being performed.

5.5. In all cases, the consulting service shall complete a consultation note for formal consultations within 48 hours or a phone communication note for phone consultations within 24 hours of the consultation.

## 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 the patient or the patient's legal representative before medical services/care can be provided at Our Children's House or as otherwise outlined in the Our Children's House General 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 Our Children's House 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 performing the procedure or treatment ("Responsible Physician") 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 to provide such information. The "Responsible Physician" has the full responsibility for the procedure or treatment being provided to the patient. The Responsible Physician of record is responsible for verifying that informed consent has been properly obtained, and if consent was obtained by a qualified designee, the Responsible Physician must co-sign the informed consent.

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, 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 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; however, the parent or legal representative shall sign the consent form as soon as possible. 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 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 Our Children's House policy for informed consent for research.

6.10. The patient shall be assigned an attending physician. A patient or the patient's parent/legally authorized representative may request a change of the assigned attending physician. When such a change occurs, all previous orders for treatment shall be canceled and new orders will be required.

6.10.1. In an outpatient setting, the attending provider role can be assigned to an APP, under the supervision of an attending physician.

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

6.11. When necessary and in the absence of the regular attending physician any member of the Medical Staff with clinical privileges may be requested by the Service Chief to attend a colleague's patient. The requested Medical 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 or APP shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements.

6.13. Clinical laboratory tests shall be performed at Our Children's House and couriered to Children's Medical Center Dallas for processing and interpretation. If a particular test needs to be sent to another outside laboratory, Children's Medical Center Dallas laboratory will select the appropriate facility, make appropriate arrangements, and provide oversite of the outside laboratory services. Children's Medical Center Dallas will send the laboratory test results performed at Children's Medical Center Dallas and any outside laboratory to Our Children's House, which will become part of the medical record.

6.14. Authenticated reports for all radiologic examinations performed on-site at Our Children's House and, when requested, review of examinations performed off-site, will be provided by Children's Medical Center Dallas. Otherwise, the attending physician or authorized licensed practitioner may record his/her own interpretation in the history or progress note section of the medical record (to include non-radiologist fluoroscopy and speech studies).

6.15. The ordering of any baseline admission testing (e.g., laboratory, imaging, electrocardiography, etc.) shall be the responsibility of the attending physician (or authorized designee) on an individual-patient basis.

6.16. Physicians or APP 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.

6.17. Designated qualified members of the Medical Staff present at Our Children's House shall respond to cardiopulmonary resuscitation codes in accordance with Our Children's House policy.

6.18. Any member of the Medical Staff who has reason to find fault with an employee of Our Children's House, 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 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 may require that the employee relinquish care of his or her patient(s) until the matter is investigated.

6.19. In the event of a patient death at Our Children's House, 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. All physicians 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.

6.21. All physicians 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.

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

6.23. Oxygen and respiratory therapy shall be administered in accordance with the attending physician's or APP's order or in accordance with established policy and protocol approved by the Medical 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 Our Children's House policies unless new orders are documented; however, prior to

discontinuing the treatment, the nurse or therapist shall notify the attending physician or APP and confirm that the treatment should be discontinued.

6.24. 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.

6.25. The Infection 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 may not believe such precautions are necessary.

6.26. Copies of imaging files and pathology slides are the property of Our Children's House and may be lent to other hospitals, physicians, or research institutions for valid reasons and upon approval of an Our Children's House radiologist or pathologist, respectively.

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

6.28. 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 Our Children's House restraint/seclusion policy and procedure shall also be met.

6.29. 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 Our Children's House, shall attempt to obtain the necessary legal means to administer blood or blood products to sustain life.

6.30. When any professional person 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 Our Children's House escalation policy. This concern may be brought to the attention of the Chief Clinical Officer OCH or the Service Chief to which the physician is assigned. When circumstances justify action, the Service Chief or the Chief Clinical Officer OCH may request a consultation.

6.31. In cases in which the radiologist's interpretation of an image significantly differs from that initially made by the physician or APP, a copy of the radiologist's report shall be made available and brought to the attention of the Patient's attending physician or attending or APP (for outpatient settings) and the patient's private physician. The patient shall be informed of any subsequent change to the patient's plan of care. The attending physician will be responsible for informing the patient of any subsequent change of care rendered.

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

## SECTION 7. Ambulatory Services

7.1. The Medical Staff shall provide medical 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 Our Children's House basic plan for delivery of such services, including the delineation of clinical privileges for all attending physicians who render ambulatory patient care. Residents and Fellows may provide care to patients under the direct supervision of an attending physician.

7.2. 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:

7.2.1. Adequate patient demographic data;

7.2.2. Pertinent medical and surgical history;

7.2.3. Description of significant clinical, laboratory, and image findings;

7.2.4. Diagnosis;

7.2.5. Treatment provided;

7.2.6. Condition of the patient on discharge or transfer;

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

7.2.8. Reconciliation of medication.

7.3. For patients receiving continuing ambulatory care, the medical record shall contain, by the third visit, a comprehensive health care summary list of the following: known significant diagnoses and conditions; known significant operative and invasive procedures; known allergic and other adverse drug reactions; and known long-term medications prescribed for or used by the patient including over-the-counter and herbal treatments.

## SECTION 8. Resident's Scope of Practice

8.1. Residents must meet the qualifications for Resident eligibility outlined in the "Essentials of Accredited Residencies in Graduate Medical Education" in the American Medical Associate's Graduate Medical Education Directory.

8.2. 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.

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

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

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

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

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

8.3.5. Participation in institutional orientation and education programs;

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

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

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

8.3.9 Compliance with Our Children's House policies and procedures, Rules and Regulations, contracts, and institutional agreements.

## SECTION 9. Faculty Permit Physicians Scope of Practice

9.1. Physicians who hold faculty permits must meet the qualifications for Active, Courtesy, or Consulting category membership of the Medical staff. They may exercise the Active, Courtesy, or Consulting prerogatives outlined in the Medical Staff Bylaws except as limited by this Section.

9.2. 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 Our Children's House.

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

## SECTION 10. Adoption, Review, and Amendments of the Rules and Regulations

10.1. The Medical 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 Staff Bylaws.

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

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

**ADOPTED BY THE BOARD OF DIRECTORS ON DECEMBER 19, 2019.**