**CHILDREN'S MEDICAL CENTER PLANO**

# RULES

# AND

# REGULATIONS

# OF THE

# MEDICAL / DENTAL STAFF

children's health
Children's Medical Center Plano

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

1.1. A patient may be admitted to Children's Medical Center Plano ("Children's Plano" 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 Plano 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 Service Chief shall be contacted, and the appropriate chain of command shall be followed.

1.5. Children's Plano is a setting for the education of Residents, Fellows and medical students. While patients at Children's Plano 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 Plano and University of Texas Southwestern Medical Center ("UT Southwestern").

1.6. Except as otherwise provided in Children's Plano policies, no patient shall be transferred within Children's Plano 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 Plano 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 Plano, and who is known or suspected to be suicidal, has taken a chemical/drug overdose, or is otherwise suspected to exhibit 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 Plano 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 Plano 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 Plano AMA without signing the appropriate document(s) shall be considered to be officially discharged AMA.

1.11. As medically appropriate, the attending physician, Resident, Fellow, or APP authorized by the attending physician shall discharge patients before 10:00 A.M. on the day of discharge.

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 Plano;

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

1.13.4. Adhere to Children's Plano 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 healthcare facility for further evaluation. Authentication for patients being discharge 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 Plano and shall not be removed from Children's Plano 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 Plano 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 (HER/HIM) 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 Plano. 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 Plano 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 Plano 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 3.9 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 Plano'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/Dental Staff shall be responsible for the medical care and treatment of each patient at Children's Plano. 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 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 Plano 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 documented 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.

## 2.4. Operative Reports

2.4.1. An operative report shall be dictated or documented 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), preoperative 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 written or dictated within twenty-four (24) hours.

2.4.3. A progress note shall be entered in the medical record immediately after surgery if the operative report is dictated. The post operative progress note shall contain a description of the findings, the technical procedures used, any specimens removed, estimated blood loss, the postoperative diagnosis, and the names of the primary surgeon and assistant surgeons. When a full operative report or other high risk procedure 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 include the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

## 2.5. Discharge Summary

2.5.1. 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 Children's Plano 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 in the medical record 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 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 dictated or documented by midnight the day 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 XIII 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 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 Plano policy, by the attending, Resident, Fellow, APP. The attending, Resident, Fellow, APP, or another provider who is providing care to the patient, and who, in accordance with Children's Plano 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).

3.3. 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 Plano 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 Plano 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 as 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 Plano 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 Plano that only medication dispensed through Children's Plano pharmacy may be used at Children's Plano. 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 Plano 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/Dental staff members, to the pharmacy.

4.18. 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. The attending physician/dentist, Resident, Fellow or APP is responsible for requesting consultation when indicated and for calling a qualified consultant. The attending physician/dentist (or authorized designee) shall provide written authorization to permit another physician/dentist to attend or examine the patient except when a *bona fide* emergency precludes this being done. The attending physician/dentist (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/dentist or APP with clinical privileges at Children's Plano may be called by the physician/dentist, 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 or dentist, 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 an operative or

potentially hazardous procedure shall be recorded prior to the surgical or other 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 authorized representative is required for release of medical information to individual's not otherwise authorized to receive this information.

6.2. General consent for treatment covers services necessary to provide routine care (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/Legal Representative before medical services/care can be rendered at Children's Plano or as otherwise outlined in the Children's Plano 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 Plano at the time of the patient's admission, informed consent must be obtained by the provider performing the procedure of treatment ("Responsible Provider") prior to diagnostic or therapeutic interventions that require informed consent. Informed consent shall be obtained in accordance to the process outlined in hospital policy. The Responsible Provider is responsible for ensuring informed consent is obtained in accordance to hospital policy and statutory requirements; this duty cannot be delegated.

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 suffers from what reasonably appears to be a life-threatening injury or illness; care shall not be delayed if the attending 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 to 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").

6.10. Each patient shall be assigned an attending physician/dentist. Should a patient, parent, or other authorized party desire to change his/her attending physician or dentist, he or she has the right to do so. When such a change occurs, all previous orders for treatment shall be canceled.

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 Service Chief 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/APP, 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 Plano or in an outside (reference) laboratory recommended by the Service Chief of Pathology and approved by the Medical/Dental Staff. The Medical/Dental Staff shall take reasonable steps to assure itself that any outside laboratory sources, from which test reports are used as the official Children's Plano medical record report, (i) have an acceptable internal quality control and external proficiency testing system in place, (ii) are monitored by qualified individuals, and (iii) are in compliance with applicable state, federal and Joint Commission requirements.

6.14. The Radiology Service shall provide authenticated reports for all radiologic examinations performed under the radiologist's supervision at Children's Plano and, when requested, for review of examinations performed outside of Children's Plano 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 Plano 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 Service.

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 Plano policy and approved by the legal department.

6.18.1 The following specimens will 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
- Omentium from Dialysis placement
- Hyperplastic gingival tissue for which there is a clear etiology
- Gingival tissue removed for gingival plastic procedures
- Calculi
- Polydactylous digits

6.19. In the event of a patient death at Children's Plano, 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 Plano 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 shall be informed of any autopsies prior to the autopsy being performed.

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 Plano Transfusion Committee.

6.23. Copies of pathology slides are the property of Children's Plano and may be lent to other hospitals, physicians/dentists/APPs, or research institutions for valid reasons and upon approval of a Children's Plano 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/or 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 Plano shall respond to cardiopulmonary resuscitation codes in accordance with Children's Plano policy.

6.28. Any member of the Medical/Dental Staff who has reason to find fault with an employee of Children's Plano, 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 in the medical record. 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 Plano 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 Plano, shall attempt to obtain the necessary legal means to administer blood or blood products to sustain life.

6.33. 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 Children's Plano escalation policy. This concern may be brought to the attention of the Chief Clinical Officer or the Service Chief to which the physician/dentist is assigned. When circumstances justify action, the Service Chief or the Chief Clinical Officer may request a consultation.

6.34. In cases in which the radiologist's interpretation of an image significantly differs from that initially made by the physician, dentist, 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 APP (for outpatient settings and the emergency department) and the patient's private physician/dentist. 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.

6.35. 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 or 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 not be performed in the Emergency Department but must be performed in the surgical suite.

7.8. In an emergency case, as soon as it appears that 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 a physician on the Medical/Dental Staff at Children's Plano with clinical privileges, the patient should be admitted to the primary care physician's service, unless admission to another medical staff service is requested by the primary care physician.

7.11. At least one Emergency Services attending must be present in the Emergency Department at all times.

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 Plano; 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 Plano. When a transportable patient requires Medical/Dental Staff consultation/treatment not available at Children's Plano, the patient shall be transferred to an appropriate facility as soon as possible after being stabilized for transfer, 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 use of the Southwest Transplant Alliance Organ and Tissue Donation for Transplantation Tissue and Organ Donor 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 Plano 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 as an organ and/or tissue donor.

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 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 for transplantation shall not be involved with the decision to discontinue life support systems or the declaration of brain death.

## SECTION 9. Surgical Care

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 or diagnoses, completion of operative reports, and all sedation/anesthesia-related requirements. The requirements for informed consent also apply.

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

9.4. The responsible physician/dentist/APP shall be present within the hospital and ready to begin the 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 room/procedure room within thirty (30) minutes after arrival of the patient into the operating/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 or spinal anesthesia shall go to a Post Anesthesia Care Unit ("PACU") or directly to a critical care unit. Patients receiving only local anesthesia may be returned to their room or may go to the recovery room at the request of the physician/dentist/APP.

9.7. All patients must have a discharge order prior to transfer from the PACU, and a post-anesthesia evaluation noted 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. In the case of patients who have received care from the Anesthesiology Service, this order may come from an attending anesthesiologist, Fellow, CAA or CRNA. In the case of patients who have not received care from the Anesthesiology Service, this order must be from the attending responsible for the procedure/sedation, which preceded PACU admission. (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 for two (2) hours or longer after leaving the Phase I recovery area of the PACU 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 Services and, as indicated, by the Surgery Department.

9.11. Physicians/dentists/APPs performing surgical procedures shall report all complications to the respective Service Chief. If a Service Chief himself or herself has a complication, he or she should report it to the Service Chief of Surgery and the Chief Clinical Officer.

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 by an attending anesthesiologist, Fellow, Resident, CAA, CRNA or physician prescribing sedation and other personnel as specified in the operating room procedure manual.

9.14. All responsible physicians/dentists/APPs shall abide by the Operating Rooms policy regarding confirmation of the: identity of the patient; the proposed procedure; and the site, side and level to be operated upon. The Attending Anesthesiologist is responsible for confirming the fact that the pre-medication was correct and given in a timely manner and that the required nils per os ("NPO") status has been maintained.

9.15. All 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 which must include: contemplated choice of anesthesia for the procedure; drug history; review of the patient's physical status (using the classification of the American Society of Anesthesiologist); 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 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 otherwise 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 Anesthesiologist working together at Children's Plano. 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 Anesthesiology Service 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 Anesthesiology Service. Members of the Medical/Dental Staff and all hospital employees shall comply with these safety policies and procedures.

10.8. The Service Chief of Anesthesiology or his/her designee is responsible for medical direction of the PACU.

10.9. There shall be documentation in the medical record that discharge of each patient from the PACU has met the requirements as outlined in section 9.7 above.

10.10. Disposition of a patient from the OR/Procedure Room is the responsibility of, and must be a joint decision between, the attending surgeon 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 unintended 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 unintended 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 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 Plano 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. Psychiatric Unit

13.1. Overall clinical direction of the psychiatric unit and partial hospitalization program shall be provided by designated qualified child and adolescent psychiatrist.

13.2. A patient may be admitted to the psychiatric unit only upon the verbal or written order of the medical director of the unit or her/his designee.

13.3. The psychiatric unit shall not accept patients with acute medical problems, unless, in the opinion of the admitting physician, the psychiatric disorders are overriding and the medical problem has been stabilized and can be safely handled within the psychiatric setting.

13.4. Admissions to the psychiatric unit shall be able and willing.

13.5. Each patient admitted to the Eating Disorders unit shall be seen by the attending physician or a designee with appropriate Medical/Dental Staff privileges, preferably at the time of admission but in no case later than twenty-four (24) hours after admission. A medical history and physical examination shall be completed by a physician with Medical/Dental Staff privileges, or APP within twenty-four (24) hours of admission of a patient to the Eating Disorders unit. A psychiatric history, mental status examination, differential diagnosis, and proposed treatment plan shall be

written by a psychiatrist with Medical/Dental Staff privileges within twenty-four (24) hours after admission of a patient to the psychiatric unit.

13.6. When multidisciplinary treatment plans are used for the care of psychiatric patients, there shall be written policies and procedures relating to their use, including appropriate physician involvement.

## SECTION 14. Critical Care Unit

14.1. Patients may be admitted to the critical care unit by any member of the Medical/Dental Staff with critical care clinical privileges on a priority basis.

14.2. Beds in the critical care unit 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.

14.3. The critical care 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.

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

14.5. During times when the critical care unit is full, the Medical Director of the Critical Care Unit 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.

## SECTION 15. Resident's Scope of Practice

15.1. 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. 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.

15.2. 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.

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

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

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

15.3.3. Utilization of appropriate institutional clinical practice guidelines;

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

15.3.5. Participation in institutional orientation and education programs;

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

15.3.7. Performance of these duties in accordance with the established practices, procedures, and policies of Children's Plano, 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/dentists in training, as applicable;

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

15.3.9. Compliance with Children's Plano policies and procedures, Rules and Regulations, contracts, and institutional agreements.

## SECTION 16. Faculty Permit Physicians Scope of Practice

16.1. Physicians who hold faculty permits must meet the staff membership qualifications for Active or Courtesy of the Medical/Dental staff and may exercise the rights and prerogatives outlined in the Medical/Dental Staff Bylaws except as may otherwise be limited by this Section.

16.2. 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 Plano.

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

## SECTION 17. Adoption, Review, and Amendments of the Rules and Regulations

17.1. 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.

17.2. 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.

17.3. 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 GOVERNING BODY ON DECEMBER 10, 2020.**