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Section 1.00 General

Section 1.01 Continuous Physician Coverage

A doctor of medicine or osteopathy is responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization; and is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, or podiatric medicine. All Members of the medical staff shall provide continuous coverage for patients personally or by agreement with another Member whose clinical privileges entitle him/her to treat the patient(s) in the Member’s absence. In case of failure to provide such an alternate, the appropriate Facility Medical Executive Committee, Facility Chief of Staff, or Clinical Service Chair shall have the authority to counsel the member. If the problem persists, the member may be asked to appear before the Medical Executive Board to explain why he/she cannot meet the responsibilities of members of the medical staff. Continued non-compliance could result in the relinquishment of privileges. Should a situation arise in which a patient is not appropriately covered by their attending physician or an alternate, the case will be referred to the appropriate Medical Staff Department for further evaluation and/or action.

Section 1.02 Electronic Medical Record

Use of the electronic medical record and relevant components such as computer provider order entry and creation of documentation records is considered part of the routine practice of medicine in direct patient care including telemedicine. With the implementation of the new electronic medical record in October 2016, all members of the medical staff and non-physician providers authorized to utilize the electronic medical record, will participate in training sessions to include web-based and classroom formats. After implementation, all new practitioners must complete training within 15 days following granting of clinical privileges and prior to administering care to patients.

All members of the medical staff and credentialed users of the electronic medical record shall comply with all Baptist Health System security, privacy regulations and network use policies.

Section 1.03 Disaster Plans

Each Member of the Medical Staff shall comply with disaster plans approved by the MEB and the Board. In case patient evacuation is necessary, the Chief Medical Officer in consultation with the President of the Medical Staff and Facility Chiefs of Staff shall authorize the movement and care of patients in accordance with the System Disaster Plan. Medical Staff Members agree to relinquish direction of the professional care of their patients if necessary in such an emergency.
During disaster(s) in which the emergency operations plan (Code Grey) has been activated, the Chief Executive Officer and Medical Staff President, facility Chief of Staff or their designee(s) has the option to grant emergency privileges to licensed independent practitioners, following the policies and procedures outlined in the Medical Staff Bylaws, if the organization is unable, or potentially unable, to handle the immediate or expected patient needs. Any issues relevant to the Medical Staff will be handled and communicated effectively according to the Emergency Operations Plan.

Section 1.04 Hospital Deaths

In the event of a death in the Hospital, the attending physician, or physician designee shall pronounce the deceased within a reasonable period of time or may delegate such pronouncement to a registered nurse according to System nursing policy. The attending physician, or physician designee, is responsible for completion of the death certificate in timely manner accordance with state law. For patients who expire in a BHS Emergency Room, the emergency department physician who cared for the patient will complete the death certificate unless relieved of this duty at the request of the attending physician. For unclear circumstances and/or questions as to ultimate responsibility for completing the death certificate, the corresponding hospital Chief of Staff will have delegating authority.

Section 1.05 Patient Evaluation

A patient shall be seen within the first 24 hours after admission. (See below for more specific requirements) A daily progress note shall be included in the patient's medical record. If the patient’s needs are not addressed in a timely manner as felt appropriate by nursing personnel, this concern shall be reported to the facility Chief of Staff who shall consult with the appropriate Clinical Services Chief.

Patient admitted to the ICU – Physician on site within 8 hours to assess patient.
Patient admitted to the CDU – Physician on site within 12 hours to assess patient.
Patient with STEMI – Physician on site within no less than 30 minutes.

A baby admitted for Level II or above care shall be seen initially within four (4) hours of admission by a physician and a progress note written. Thereafter, all such babies shall be seen by a physician at least every twenty-four (24) hours with a progress note completed as documented by a progress note.

Section 1.06 Patient Information

Practitioners admitting patients shall provide such information as may be necessary to provide for the protection of other patients and Hospital staff from those patients who are
a source of danger from any cause or to enable protection of the patient from self harm. All patient health information will be handled in compliance with HIPAA requirements.

Section 1.07 Medical Staff Identification

The MEB and the Board shall develop a system of identification for Medical Staff Members according to policy as adopted. Medical Staff Members are required to wear their current citywide identification badge that provides picture identification as well as specialty-specific information. In addition, each practitioner granted disaster privileges will be required to wear a BHS issued ID badge throughout duration of disaster privileges. Medical Staff will be issued a BHS Medical Staff Services System Access card with photo identification for facility access and optional use for authentication with BHS Information Services Computerized Devices for patient care.

Section 1.08 Information Security

The BHS Medical Staff and all licensed providers granted access to BHS Information Services to include the electronic medical record, BHS computer devices, and wireless networks will comply with all pertinent BHS and Tenet regulatory policies. Providers granted such access will not share credentials (usernames and passwords) with any other person.

Section 1.09 Primary Facility Designation

Upon initial appointment, Medical Staff Members shall indicate to the Medical Staff Services Office in writing the System facility that they intend to primarily utilize. Following their initial appointment, physicians will be assigned to the system facility that corresponds to the majority of their inpatient activity, to aid in communication of items of interest, to determine where they can vote and where they will take ER call. The medical staff member can also indicate a secondary facility they will utilize that will aid in communication of items. The member will only have voting privileges at their primary designated facility. These designations may be changed at any time by notifying the Medical Staff Services Office. Physicians may change their assigned facility by showing evidence of a change in their practice location or affiliation with the anticipation that the majority of their inpatient activity will be at a different facility. Once they become established in their new practice situation, they will be assigned to the facility in which the majority of their inpatient activity occurs.

Section 1.10 Medical Staff Members Notification
Medical Staff Members are responsible for ensuring that the Medical Staff Services Office has a current office address, phone number, cell phone number and e-mail address and is promptly notified of any changes. Notification to the address on record for the Member shall be considered notice to the Member.

Section 1.11 Use of Ethics Committee

Facility Ethics Committees may be available for consultation with any practitioner, Hospital staff, patient or family member in accord with System Policy. Any questions regarding procedures or conflict between a practitioner or Hospital staff and a patient and/or legally authorized representative or family member may be referred to the Ethics Committee for review and advice. Should a facility ethics committee not be available for these consultations, the request will be forwarded to the System Ethics Committee. The System Ethics Committee also oversees the work of the Facility Ethics Committees.

Section 1.12 CME

Continuing medical education is encouraged and supported by the medical staff and Baptist Health System.

The requirement for CME for BHS Medical Staff members shall be that of the Texas State Licensing Boards. Documentation of CME shall be maintained by the medical staff member. Other Dentists and Podiatrists shall complete the number of CME hours required by their State licensing Board.

Section 1.13 Patient Identification

Medical Staff Members shall use two forms of patient identification in compliance with the National Patient Safety Goals. The patient’s name and account number shall be used to identify the patient for the right care and procedure.

Section 1.14 Hand-Off Communication

Medical Staff Members shall ensure that important patient information is communicated from one physician to another whenever there is a transfer of care between the physicians. Hand-off Communication can be verbal or written to ensure that each attending physician has all the necessary information to provide safe and quality care.

Section 1.15 RCA (Root Cause Analysis) Participation
Medical Staff Members shall participate in any Root Cause Analysis (RCA) that is in direct relationship to the care or services rendered to their patient.

Section 1.16 National Patient Safety Goals

Medical Staff Members shall participate in all activities that are associated with the National Patient Safety Goals implemented within each facility. These activities include but are not limited to: Time Out prior to procedure, Marking of Site prior to procedure, Fall Prevention, Do Not Use Abbreviations, Hand Hygiene best practices etc.

Section 1.17 HIPAA Oral Communication – Patient information that is disclosed in conversation among providers should be appropriate and relevant to patient care. All oral communication should be discreet and conducted away from public areas, when possible to protect patient privacy.

Use of Cell Phones - Cell phones should only be used for appropriate conversations while on facility grounds. Pictures should only be taken with approval from patients per BHS policy. Inappropriate use of a cell/camera phone is a violation of HIPAA and grounds for suspension of medical staff privileges.

Per The Joint Commission, “it is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare setting. This method provides no ability to verify the identity of the person sending the text and there is no way to keep the original message as validation of what is entered into the medical record.”

Access to Records – Access to records shall be available to Members who have a medical need for information (for current care of a patient) or have a need for record access to fulfill a staff responsibility. The confidentiality of patient information shall be preserved at all times.

Section 1.18 Physician Response Time

Physicians who have current in-patients or patients receiving treatment at a BHS facility are expected to respond to calls and /or pages from the facility within 30 minutes. Response could be by phone to assist in the necessary care/treatment of the patient or the emergent needs for the physician to be on site.

Section 1.19 Treatment of Self and/or Family Members

Physicians generally should not treat themselves or members of their immediate families except in emergencies or in cases in which no other qualified practitioner is available.
Professional objectivity may be compromised when an immediate family member or the physician is the patient. The physician’s personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician’s professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member’s personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV)

Section 2.00 Admissions & Discharges

Section 2.01 Admissions

Patients shall be registered to the System Hospitals and designated as inpatient, outpatient, observation, or other services only on the order under the authority of a Member of the Medical Staff who is privileged to admit. An admission order of designating the appropriate status type and including the admitting diagnosis shall be entered by the admitting physician or by an appropriately privileged NPP under the admitting physician’s authority into the electronic medical record. System Hospitals shall admit patients according to available facilities and services consistent with established System Policy. In the event an outpatient or observation assignment is converted to a full admit, the request for the change will be noted in the medical record order section or progress note by the Member stating the justification for each admission.
status. Members of the Medical Staff are expected to choose and/or modify the appropriate admission category for all patients admitted and cared for in the facility.

Section 2.02 Transfer of Care

Whenever the care of a patient is transferred to another Staff Member, the transferring Member shall enter an order requesting the transfer in the patient’s medical record. Transfer is effective when the receiving member—physician documents acceptance of the patient in the medical record.

Section 2.03 Discharge

A patient shall be discharged from the Hospital by order of the patient’s attending practitioner, practitioner designee or consultant utilizing and completing all the elements of the discharge process in the electronic medical record. In the instance when a practitioner designee or consultant discharge the patient, it is important to patient care continuity to inform the attending physician and/or the primary care provider of the patient’s discharge status. When a co-admission requirement exists, a co-discharge agreement shall be required. Should a patient leave the Hospital against the medical advice (AMA) of the attending practitioner, or without proper discharge, a notation shall be made in the patient’s medical record. Patients who propose to leave the Hospital against the medical advice of any Staff Member shall, if at all possible, be required to sign a statement (AMA Release) to this effect in accord with System Policy.

Section 2.04 Discharge Planning

Discharge planning for patients shall not require a practitioner’s order and shall be undertaken according to System Policy.

Section 2.05 Psychiatric Patients

A psychiatric consultation shall be obtained on all suicidal and actively symptomatic patients, and if their medical condition allows, these patients should be admitted or transferred to a psychiatric unit or a nursing unit where the patient can be under the constant direct observation of qualified nursing staff. Alcohol and drug addicted patients shall be admitted for emergency treatment of medical conditions only. Patients requiring psychiatric treatment as soon as stabilized shall be transferred to a facility where appropriate psychiatric therapy and treatment can be provided upon stabilization of their medical condition.

Section 2.06 Admission Consent Form
A general consent form, signed by or on behalf of every patient admitted to the System, shall be obtained at the time of admission. The Hospital shall notify the attending practitioner whenever such consent has not been obtained.

Section 3.0 Consultations

Except in an emergency situation, consultation shall be considered when the needs of the patient require clarification or confirmation. Consultation is recommended in the following situations:

1. When the risk for operation or treatment is uncertain.
2. When the diagnosis is uncertain after ordinary diagnostic procedures have been completed.
3. When there is doubt as to the appropriate choice of therapeutic measures.
4. In unusually complicated situations where specific skills of other practitioners may be deemed helpful.
5. In instances in which the patient exhibits severe psychiatric symptoms or suicidal tendencies or attempts.
6. When requested by the patient or the family.

All consultations are required to be from one physician to another. The physician requesting the consultation from another physician must enter an order identifying the consultant to the care team. The physician requesting the consultation will also contact the consultant with the appropriate clinical information to include the reason for the consultation. The expectation is that the consultant will see the patient within 24 hours. A consultation request from a non-physician will not be considered a formal request to see a patient.

If System personnel have concerns related to the condition of any patient including whether consultation may be advisable, these concerns shall be directed to the attention of the nursing supervisor. If warranted, the Chief Medical Officer of the System may request assistance from the Chief of Staff of the facility. When circumstances justify, the Chief of Staff of the facility or President of the MEB may require that the attending physician request a consultation from a qualified consenting Member of the Medical Staff.

Section 4.00 Orders

Section 4.01 Orders and Protocols

Members of the Medical Staff will utilize the electronic medical record as a part of the routine practice of medicine to enter admission and treatment orders in a format approved by the MEB. Such orders shall be made specific for each patient as necessary by
additional instructions and shall be authenticated in the electronic medical record by the practitioner. Personal provider order sets will not be accepted by the hospital staff as per MEB policy with the exception of elective procedural orders so as to support installation of a new EMR for BHS in October 2016. Cutoff for acceptance of this select group of order sets will be the end of first quarter 2017. New order sets and modifications to existing order sets are to be vetted by means of the following process: the respective medical staff department/service line, the BHS Clinical Order Set Advisory Committee, the Medical Staff Informatics Committee and finally the MEB.

Protocols may be developed for special care areas in cooperation with Nursing Service and Administration and shall be approved by the appropriate Committees noted above.

Section 4.02 Automatic Cancellation of DNR Orders at time of surgery

Do not resuscitate (DNR) orders shall be automatically canceled with the consent of the patient when a patient goes to surgery and reinstated post-operatively as appropriate.

Section 4.03 Patient Orders

All orders for patient care and services (in-patient and out-patient) shall be given by a member of the BHS Medical Staff or privileged/credentialed Allied Health Professional under his/her direct supervision/responsibility at the Medical Staff member’s request. Scribes utilized by the BHS Medical Staff to assist in creating patient care documentation are not licensed providers and therefore not allowed to give or enter patient care orders unless directly supervised by the credentialed practitioner. Patients referred to the hospital for treatments under the care of the referring physician (i.e. a blood transfusion) must provide present with the orders, the reason for the visit, a diagnosis, allergies, and a brief history on the patient. Out-patient orders will be honored up to 30 days from the date of the order.

Patients referred to the hospital for diagnostic procedure to be performed by another practitioner (i.e. fluro guided biopsy) should have the reason for the visit, a diagnosis and allergies. The treating physician should perform his/her own brief history and physical. The in-patient All orders shall be included entered into the electronic medical record using computer provider order entry when possible or unless meeting one of the conditions below.

An exception to electronic order entry includes the types noted below. The following orders shall be provided in writing; verbal and telephone orders will not be accepted for:

1. Chemotherapy drug orders
2. Investigation drug orders
3. Device or procedural protocols
4. Orders to withhold or withdraw life support
Home chemotherapy agents ordered as part of the medication reconciliation process may be taken as a telephone order by a registered nurse or pharmacist.

Two means of identifying the patient are required when giving telephone and verbal orders to confirm patient identification. One of the identifiers must be the patient’s name. The second patient identifier is to be selected from the following:

1. Age or date of birth
2. Diagnosis, procedure/surgery (if applicable), and physician name
3. Gender
4. Account Number

Section 4.04 Verbal/Telephone Orders

Verbal orders are orders for medications, treatments, interventions or other patient care that is communicated as oral, spoken communications between senders and receivers face to face or by telephone. The use of verbal orders in non-emergent situations when the prescriber is immediately present, are discouraged and allowed only when the provider has no computer access in a timely manner. Verbal orders must be:

- Dated and timed,
- Signed Authenticated in the electronic medical record by the prescribing practitioner and/or another physician with responsibility for the patient. As soon as possible would be the earlier of the following
  - The next time the prescribing practitioner and/or another physician with responsibility for the patient provide care to the patient, assesses the patient, or documents information in the patient’s electronic medical record.
  - Within 96 hours of when the order was given.

Verbal orders can be given to any State or Federally licensed/certified/or registered health care professional with a scope of practice that permits receiving telephone or verbal orders related to their practice. This may include, but is not limited to, Registered Nurses, Licensed Vocational Nurses, Licensed Social Workers, Pharmacists, Licensed Physical Therapists, Certified Respiratory Care Practitioners, Registered Dietitians, Registered Medical Laboratory Technologists or Technicians, Certified Medical Radiology Technologists, Licensed Occupational Therapists, Speech Therapists or Audiologists, and Licensed Perfusionists.

The individual receiving the verbal or telephone order(s) shall verify the identity of the patient with at least, two identifiers. Accuracy of the order(s) will be confirmed by entering the order in the electronic medical record and then reading the order back to the individual giving the order with verification that the electronically entered order was correct to include all electronic medical record clinical alerts and reminders. Verbal or Telephone order(s) are then electronically signed by the individual receiving the order indicating the name of the Medical Staff member or privileged Allied Health Provider.
The order(s) will be flagged for signature by the Medical Staff member or privileged Allied Health Professional by forwarding the electronic order to the message center in the electronic medical record.

- Additional telephone Orders provisions – there are two exceptions to the 96 hour time frame in Texas.
  - b. Admission Orders to a Behavioral Health Unit – the Texas Administrative Codes requires a 24 hour time frame for telephone admission orders to a Behavioral Health Unit.

Verbal/Telephone orders should only be given in those rare circumstances when computer access for electronic order entry is not readily available.

Section 4.05 Admission Lab

There are no requirements for routine laboratory work on admission to the Hospital or for outpatient procedures. Laboratory results, if done in a laboratory with current CLIA Certificate, may at the discretion of the attending practitioner, be incorporated into the patient record. The appropriate laboratory reports shall be placed in the medical record prior to any procedure being performed. The practitioner shall be responsible for determining the proper pre-procedure lab required for operative and other invasive procedures (inpatient and outpatient) and determining the proper time frame to obtain or repeat lab tests, unless otherwise provided by Medical Staff Policy.

Section 4.06 Drug Standards

Drugs administered ordered for administration in the System shall meet the requirements of the U.S. Pharmacopoeia, National Formulary, or New and Non-official Drugs, including nutraceuticals, with the exception of drugs approved for clinical investigation(s) by the IRB. Additional standards for drugs may be established by the Pharmacy and Therapeutics Committee and approved by the MEB and Board.

The Pharmacy and Therapeutics Committee shall update the formulary based on clinical evidence and cost-benefit evaluation. Pharmacies shall stock only formulary drugs recommended by the Pharmacy Committee and approved by the MEB plus those drugs restricted to clinical investigations approved by the IRB.

Investigational drugs shall be handled in compliance with Food and Drug Administration regulations. The practitioner shall obtain approval for the use of investigational drugs from the IRB prior to the use of such drugs. Investigational drugs shall be dispensed
from the Hospital Pharmacy upon the request of the practitioner investigator authorized to conduct the study. Use of a drug for a non-approved use (off label) shall not require review or approval by any committee or the IRB.

Section 4.07 Dosage Time

Medications shall be given at designated administration times according to System policy or in accord with a practitioner’s specific order, with the exception of antibiotics whose first dose will be at the next whole hour and then dosed at times according to the specified administration interval.

Section 4.08 Medication Orders

Medication Orders, defined by System Policy and approved by MEB, must be entered into the electronic medical record using computer provider order entry and shall include:

1. Time and date of order
2. Drug name and dose (strength and dosage form, if necessary)
3. Directions for use (including frequency and route of administration)
4. Prescriber's electronic signature or that of his or her authorized agent
5. Weight based dosing for pediatric orders (age 12 and under), vasoactive drips, or other medications requiring dosage calculations based on the patient’s weight.

All orders for chemotherapy agents used in treating either oncological or non-oncological conditions must include an indication.

- All orders for anti-infective agents whether for empiric therapy or treatment of documented infections.
- All “PRN” (as needed) orders require an indication.

The use of “AS NEEDED” (PRN) and “ON CALL” with medication orders shall be qualified so there is no question as to the prescriber's intent (i.e. a symptom or indication for use is included with the prn order) either in CPOE or when paper written orders are used in downtime situations.

Blanket resume medication orders (e.g. "Resume home medications", "Resume pre-op medications") are not valid. Texting of orders by providers to the hospital staff is not allowed.

Section 4.09 Drug Stop Orders

The purpose of the Drug Automatic Stop Order (ASO) is to establish a reasonable time, determined by the Medical Staff, to stop administration of drugs and biologicals not specifically ordered as to time or number of doses. Drugs shall not be discontinued without the prescribing practitioner being notified, unless the prescribing practitioner’s order indicated a set number of doses or days of therapy.
Drug orders for the following categories shall be reviewed and continued or discontinued at the stated frequency consistent with the current Pharmacy and Therapeutics Committee policy:

Narcotics, Hypnotics, Sedatives and Anxiolytics seven (7) days. Anticoagulants, Antifungals and Antibiotics ten (10) days. Hyperalimentation twenty-four (24) hours, with the exception of Clinimix peripheral solutions with no additives.

All other drugs shall be reviewed and renewed or discontinued every thirty (30) days. The Electronic Health Record will automatically provide renewal messages to plan in addition. Tenet Healthcare has developed a list of other selected medications in categories including narcotics, hypnotics, sedatives, Anxiolytics, anticoagulants, antifungals and antibiotics where the electronic health record provides automated renewal messages at earlier intervals. The Pharmacy shall provide notification in the patient record at least forty-eight (48) hours prior to the intended discontinuance.

Stop times for specific drugs not covered above may be addressed by a recommendation from the Pharmacy Committee approved by the MEB and communicated with the Medical Staff.

Practitioners are to enter specific orders for drugs with a definite duration, route, indication, and frequency indicated into the electronic medical record using computer provider order entry.

Section 4.10 Therapeutic Substitution

Generic equivalents are routinely substituted for brand name drugs of the same strength and bioavailability. Therapeutic substitutions with drugs in the same class shall be allowed only if the Pharmacy and Therapeutics Committee and MEB have approved the substitution. For each therapeutic substitution, the Pharmacy and Therapeutics Committee shall specify practitioner notification requirements.

If a patient has a medical indication for a non-formulary drug, the practitioner shall enter the order with “No substitution” along with the clinical justification in the electronic medical record using computer provider order entry. The Directors of Pharmacy shall report off-formulary drug utilization to the Pharmacy and Therapeutics Committee.

Section 4.11 Restraint and Seclusion Orders

1. Restraint and seclusion shall require a practitioner’s order utilizing the BHS electronic health record provider order entry and may only be utilized in accord with System Policy approved by the MEB.
2. Restraint orders shall comply with the requirements of The Joint Commission, CMS and state law.
3. Orders for restraint and seclusion shall be dated and timed by the ordering physician.
4. There shall be no PRN orders for restraint or seclusion.
5. Following the initial period of use of restraints, the practitioner shall personally evaluate the patient face-to-face prior to placing an order to continue medical or behavioral restraints.
6. Restraint orders for behavioral health and/or seclusion shall require a face-to-face evaluation by the provider within one hour of initiation of the restraint and/or seclusion.

Section 4.12 Advance Directives and Documentation of Code Status

Practitioners shall comply with advance directives as set forth in System Policy. Orders for withholding or withdrawing life-sustaining treatment shall be issued in accord with System Policy and must be entered into the electronic medical record by the attending or covering practitioner, or his or her designee, and confirmed in the progress note section. No in-facility verbal orders will be accepted. Telephone orders require two nurses for acceptance. Questions regarding advance directives or the withholding or withdrawal of life-sustaining treatment may be referred to the Ethics Committee or Administration for review and advice. Documentation of Resuscitation Status (Code Status) shall be entered as an order into the electronic medical record as a part of routine admission and current care orders.

Section 4.13 Medication Reconciliation

Medical Staff Members shall complete the medication reconciliation process on all patients using the electronic medical record for all phases of this process. Reconciling patient’s medication is a Patient Safety Goal and provides a means of identifying, which medications a patient should continue upon admission, transfer, or discharge. The medication reconciliation process is a three step process: 1) Creating a complete and accurate list of all pre-admission medications (entered by the nursing staff on admission); 2) Using this list when comparing medication orders; and 3) comparing this list against the physician’s admission, transfer, and/or discharge orders for any discrepancies. When completing the discharge medication reconciliation process, the physician will enter the indication for the medication as a best practice.

Section 4.14 Mandatory Order Sets and CPOE Compliance

Medical Staff Members shall complete the MEB mandated Core Measure order sets on all patients being treated for Core Measure conditions and Stroke. These order sets are written in accordance to the Core Measure Sets that are set forth by the Joint Commission and CMS. The Mandatory Order Sets align common measures that capture data needed
to prove compliance with regulatory guidelines and maintain data integrity in the BHS Stroke Program. The Medical Staff will also utilize preferentially their respective service line and department approved order sets provided in the electronic medical record Baptist Health System order set catalogue. As needed, MEB approved updates and revisions to the medical staff order sets will be released from time to time requiring providers to transfer the updated or new order set to their personal order set catalogue folder within the electronic medical record for use on their patients.

Medical records will be audited for compliance with required elements as outlined in this document. These audits will be a routine component of Peer Review. The results will be shared with the supervising Medical Staff Department Peer Review Committee, System Medical Staff Quality/Peer Review Committee, Professional Standards Committee, the Medical Executive Board and individual practitioners. Providers identified as not being compliant with required elements will be considered for administrative suspension after a staged remediation process to include committee letters, re-training and provider appearance before supervising medical staff committees named above.

Section 5.00 Surgery and Invasive Procedures

Section 5.01 Pre-Procedure Records

A history and physical examination shall be available on the patient’s chart (preferentially the electronic medical record) before any surgical or invasive procedure is undertaken unless the physician documents in the medical record that any delay incurred for this purpose would constitute a hazard to the patient. See timing and required elements in Section 7.03. A pre-procedure diagnosis and results of appropriate lab and diagnostic tests shall be documented in the medical record.

The physician (referring physician) who sends his/her patient to BHS to receive an outpatient procedure (Invasive Non-Surgical that does not involve sedation) must have privileges in the Baptist Health System. There are 2 reasons a doctor might send a patient:

1) For blood or IV therapy (antibiotics etc.) - in this case the referring physician is still actually directing the care. He/she is responsible for the medication reconciliation, known allergies, etc.

2) For a diagnostic procedure (radiology directed biopsy). The (treating) physician performing the procedure is directing the patient’s care. He/she has more responsibility (medication reconciliation, known allergies, etc.) The (treating) physician must provide the reason for the visit, a diagnosis, and brief history on the patient. The physician will need to provide documentation of informed consent.

Section 5.02 Informed Consent Required

Except in documented emergencies, it shall be the responsibility of Members of the Medical Staff to obtain informed consent for treatment from the patient or their legal representative. Consent shall be documented in the medical record by the practitioner
performing the procedure prior to the commencement of any treatment or procedure. Consent shall be consistent with Texas law, including disclosure of risk for the procedures established by the Texas Medical Disclosure Panel and System Policy. Written consent shall be obtained using the Hospital’s approved forms. Telephone consent for all treatments, procedures and autopsies may be obtained according to System Policy, if needed. BHS Consent Policy # RM-PR-01.

Section 5.03 Assistant Required

For surgeries in which a surgical assistant is required a (non-physician) appropriately credentialled Certified First Assistant may be used. Surgeons wishing to use first assists have the responsibility to identify and request their assistance. It is not the hospital’s duty to ensure a first assist is available for a given procedure. Procedures requiring assistants are set by the clinical services. Allied health professionals may not act as primary surgical assistants on cases designated as requiring a Member assistant surgeon. Allied health professionals may be utilized according to Policy developed by and approved by the Credentials Committee, the MEB and BHS Board.

Section 5.04 Operative Note/Report

An Immediate/Brief Operative Note and Operative Report are required on all procedures including operative, other invasive and noninvasive procedures that place the patient at risk.

Upon completion of the operation or procedure and before the patient is transferred to the next level of care, a brief Operative Note shall be entered in the electronic medical record progress notes recording the date and time the brief Operative Note is written, the name(s) of the primary surgeon and assistants, pre-operative diagnosis, post-operative diagnosis, name of the procedure being performed, findings, specimens removed, and estimated blood loss.

A comprehensive Operative Report shall be dictated immediately upon completion of the operation or procedure. The Operative Report shall include:

A. Name and hospital identification number of the patient – (this would be via the EMR or patient identification label)
B. Date and times of the surgery
C. Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision)
D. Pre-operative and post-operative diagnosis
E. Name of the specific surgical procedure(s) performed
F. Type of anesthesia administered
G. Complications, if any
H. A description of techniques, findings, and tissues removed or altered;
I. Estimated blood loss
J. Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary
surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) K. Prosthetic devices, grafts, tissues, transplants, or devices implanted if any.

the date of the procedure, the name(s) of the primary surgeon and assistants, preoperative diagnosis or medical indication for the procedure, postoperative diagnosis, name of the procedure being performed, technical procedures used, findings, specimens removed, and estimated blood loss. The Operative Report is to be authenticated in the electronic medical record as soon as possible following the procedure. Comprehensive Operative Report shall be created by means of the BHS provided dictation system or from the electronic health record documentation templates.

Section 5.05 Surgical Specimens

All surgical specimens shall be sent to the Hospital laboratory for examination in accordance with System Policies. Exemptions shall identify those specimens not requiring examination by Pathology and must be approved by the MEB and Board.

Section 5.06 Post-Operative and Post-Procedure Care

The care of a patient throughout the appropriate surgical post-operative or post-procedure period shall be the responsibility of the surgeon, physician performing the procedure, or a qualified practitioner designee unless the patient is admitted to an ICU, at which time they become the responsibility of the intensivist (with appropriate input from the proceduralist).

It is also the responsibility of the surgeon performing the procedure to explain in detail to the patient/family member(s) or designee the procedure before it takes place. When the procedure is completed, it is the explicit responsibility of the surgeon to discuss the disposition of the patient and outcome of the surgery with the family members or the designee.

Section 5.07 Surgery and Invasive Privileges

The Medical Staff Services Office shall maintain a record of the current clinical privileges of each member, which shall be available to the Hospital Staff. Each member shall be held responsible for scheduling invasive procedures only as permitted by his/her privileges. Members scheduling outside of the scope of his/her credentialed privileges shall be referred to the facility Medical Executive Committee and System Credentials Committee for consideration of corrective action.

Section 5.08 Admission for Surgery and Invasive Procedures

Except in emergency cases, patients scheduled for surgery and invasive procedures shall be admitted requested to appear at the surgical area in a timely manner prior to the
scheduled time of surgery sufficient to allow for proper patient preparation and medication. The proceduralist will enter into the electronic medical record for their patient any preoperative orders and documentation needed for such procedure prior to their patient’s preparation by hospital staff.

Section 5.09 Surgery Start Time

It is the expectation of the Medical Staff that all personnel participating in procedures, surgeries and anesthesia shall be present and available in the operating/procedure room and ready at the time the case has been scheduled. Repetitive late starts may result in disciplinary action against the offending practitioner by the Medical Staff. Starting a case more than thirty (30) minutes after the scheduled time shall be at the discretion of the OR or Area Supervisor following consultation with the involved practitioner.

The assistant surgeon, if required, shall be available in the Hospital before surgery is started. The decision to begin surgery shall be at the discretion of the surgeon.

Section 6.00 Anesthesia

Specific details on Moderate Sedation are outlined in the System Sedation and Anesthesia Policy.

Section 6.01 Pre-sedation/Pre-anesthesia Assessment

Prior to any operative or other procedure in which the patient will receive general, spinal, major regional anesthesia, moderate or deep sedation, the physician and/or anesthesiologist shall conduct a pre-sedation or pre-anesthesia assessment which includes a physical examination of cardiac, respiratory system and airway including a reassessment immediately prior to induction, and document the findings in the electronic medical record per the Sedation and Anesthesia policy.

Section 6.02 Operative and Postoperative Evaluation

Any difficulties encountered during the administration of the anesthetic, and the condition of the patient at the conclusion of the operation shall be noted in the medical record. The Anesthesiologist shall maintain and document a complete anesthesia record during all procedures that utilize anesthesia.

The anesthesiologist shall be responsible for the assessment of patients during the post-anesthetic recovery period and shall record a post-anesthetic note dismissal from the recovery room shall be by order of the anesthesiologist or by policies approved by the MEB.
Section 6.03  Anesthesia Informed Consent

Except in documented emergencies, it shall be the responsibility of Members of the Medical Staff to obtain informed consent for anesthesia from the patient or his legal representative. Consent shall be documented in the medical record by the practitioner prior to the commencement of any treatment or procedure. Consent shall be consistent with Texas law, including disclosure of risk for the procedures established by the Texas Medical Disclosure Panel and System Policy.

Section 7.00  Medical Records

Section 7.01  Hospital Records

All information contained in medical records, radiology films, pathology materials, original tracings of tests and other original records is the property of the patient and shall be shared with him or her at their request. The physical records containing this information are the property of the System and shall not be removed from the System except upon receipt of a court order or as required by statute. Release of copies of medical records shall be in accordance with Hospital Policy.

Physicians, Allied Health Practitioners, and other healthcare team members who provide documentation in the patient medical record are required to utilize the electronic health record and in those few circumstances where medical records remain on paper such as electronic medical chart downtimes— and are to be written legibly. Illegible penmanship is a patient safety issue. Illegible penmanship can result in disciplinary action. Use of scribes by the medical staff to assist in creation of patient care documentation will follow applicable Tenet policy.

Electronic documentation that is placed in a “save” status will be finalized within 24 hours.

Section 7.02  Medical Records Information

It shall be the responsibility of the attending practitioner to prepare a complete medical record of each patient to include but not be limited to: identification data, chief complaint, history of present illness, past medical history, family history, social history, organ system review, physical examination, diagnostic and therapeutic orders, special and procedural reports (such as consultation, clinical laboratory, radiology reports, and others), clinical observations, provisional diagnosis, medical or surgical treatment, operative reports, progress notes, final diagnosis, condition on discharge, discharge summary and follow-up or autopsy report when available.
All forms to be included in the medical record shall be approved by the appropriate medical staff committees prior to being utilized such as system department committees and/or the Medical Staff Informatics Committee. Any forms requiring physician completion will be sent to MEB for review and approval.

Each provider shall be responsible to follow Tenet policy regarding appropriate use of copy/paste or carry-forward and auto-populate functionalities in the creating documentation in the electronic medical record concerning their patient. Provider requests for printing of medical records information for routine patient care support is strongly discouraged as information obtained may be obsolete. This will also conform to hospital best practice print reduction stewardship.

Section 7.03 History and Physical Examination (H&P)

• Timeliness Requirements

A complete history and physical examination shall be performed and documented in the electronic medical record within twenty-four (24) hours following admission of the patient, but prior to surgery or other procedures. An admission note shall be entered into the electronic medical record as soon as possible upon admission.

History and Physical Examinations performed within thirty (30) days prior to admission may be used if the following requirements are met:

1. The physician enters an update note, which is attached to the H&P. This update exam should include any changes to the physical examination that may have changed since the original H&P. The physician must document that they “have examined the patient”.
2. The H&P and any updates/assessments must be included in the patient’s medical record within twenty-four (24) hours of admission, but prior to surgery or other procedures.

An H&P performed more than thirty (30) days prior to hospital admission, outpatient observation, or outpatient surgery does not comply with timeliness requirements and a new H&P must be performed.

In the instance when a patient is admitted as an inpatient with a timely H&P and has a subsequent procedure during the same admission, the ongoing progress notes constitute the update to the H&P.

• Medical Records Requiring a History and Physical Examination

History and Physical Examinations are best if dictated—An H&P is required on all inpatient visits, outpatient observation visits, and outpatient surgery visits and must be done within 24 hours of admission, or within 30 days prior to an admission.

The H&P must be documented prior to operative and other procedures except in an emergency situation that is documented in the medical record. Elective inpatient or
outpatient surgery/invasive procedures will be canceled or delayed until a complete history and physical examination is recorded in the medical record. Evaluation of the declared emergency status and any discrepancies will be referred to the appropriate facility MEC as needed. It is the responsibility of the physician to meet these requirements.

- **Elements of a History and Physical Examination**

The content of the H&P may vary depending on the level of care, treatment or services provided. Therefore, the medical staff has defined the minimum content requirements as follows:

**INPATIENTS:**
The complete history and physical shall be obtained for all inpatients and include:

**HISTORY:**
- Chief complaint
- Present Illness including, when appropriate, assessment of emotional, behavioral, social status
- Relevant past medical, family and social history, appropriate to age of patient
- Allergies
- Review of body systems

**PHYSICAL** - Comprehensive current physical examination including:
- Vital signs (EXCEPTION: vital signs obtained and recorded as part of admission nursing assessment will be accepted for scheduled procedure patients only)
- HEENT
- Neck
- Heart
- Lungs
- Breast, genitalia, rectal, pelvic exams – EXCEPTION: In the instances where these exams are not appropriate based on the age and/or condition of the patient and are deferred; the physician should document reason for deferral.
- Abdomen
- Extremities
- Neurologic
- Laboratory data, if available.
- Assessment of findings and plan of treatment

**NON IN-PATIENTS UNDERGOING MEDICAL OR PROCEDURE REQUIRING MODERATE SEDATION/ANESTHESIA**
For non-inpatients undergoing medical/prenatal observation or procedures that require sedation/anesthesia, at a minimum a Focused History and Physical must be obtained. The minimum required content of a Focused History and Physical will include:
• Chief complaint/indication for procedure (including pre-procedure diagnosis)
• Pertinent and relevant history, including social and family history as applicable; and
• Review and physical examination of cardiac, respiratory system, and other systems relevant to the procedure.
• If a patient converts to an inpatient status, the history and physical will be augmented to cover all required elements of an inpatient history and physical as outlined above.

NON-INPATIENTS UNDERGOING MINIMALLY INVASIVE NONCOMPLEX PROCEDURES REQUIRING LOCAL ANESTHETIC
For non-inpatients requiring minimally invasive procedures, which generally use local anesthetics, at a minimum the following documentation is required:
• Chief complaint/indication for procedure (including pre-procedure diagnosis)
• An examination pertinent to the procedure proposed to be performed and any co-morbid conditions

NON-INPATIENTS UNDERGOING NON-INVASIVE NON-COMPLEX PROCEDURE OR BEDDED STAY
For non-inpatients undergoing a non-invasive, non-complex procedure or bedded stay, at a minimum the following documentation is required:
• Chief complaint/indication for non-invasive/non-complex procedure or bedded stay. Example would be to receive a medication.
• Problem list
• Any allergies or other co-morbid conditions.

CHEMOTHERAPY PATIENTS
For this type patients (e.g. Chemotherapy), undergoing outpatient invasive procedures NOT requiring sedation/anesthesia, there must be a physician managing the care of that patient.

PRENATAL H&P
It is recognized that the prenatal patient is a special situation in that, in and of itself, the prenatal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy. At a minimum the following elements must be included in the physical exam upon admission: heart, lungs, abdomen, pelvis, and assessment of the fetal status; as well as the Reason for Admission, Problems with Present Pregnancy, Assessment and Plan.

The following are additional requirements for the prenatal H&P:
• Patient with Prenatal Care Record – An Obstetrical Admission History and Physical Form should be used or an interval note made to complete any missing required elements that are not included in the patient’s Prenatal Record.
  • Patient Presenting with No Prenatal Care – Obstetrical Admission History and Physical Form must be completed.
SERIES PATIENTS
For series type patients (e.g., Wound Care), undergoing outpatient invasive procedures requiring sedation/anesthesia, an interval assessment must accompany the H&P prior to procedure. The interval assessment should include physical examination of the patient to update any components of the patient’s current medical status that may have changed since the prior H&P. If a Series Patient is admitted as an inpatient, the minimum requirements for inpatients apply, including timeframe for completion apply.

For series type patients (e.g., Physical Therapy), undergoing outpatient services, there must be a physician managing the care of that patient. Example: Physical therapy communicates the patient’s progress to the managing physician.

ANESTHESIA/SEDATION COMBINATIONS
Anesthesia/Sedation combinations require a history and physical relevant to the highest level of anesthesia/sedation provided, (e.g., local with moderate sedation requires an H&P as described for moderate sedation).

ADDITIONAL H & P REQUIREMENTS:
If a patient converts to an inpatient status, the history and physical will be augmented to cover all required elements of an inpatient history and physical as outlined below.

- Authentication
The H&P shall be completed and authenticated within 24 hours of admission or prior to surgery whichever comes first.
Medical Staff Members are not to pre-date an H&P or any other document as this can be construed as falsification of the medical record.
All or part of the H&P may be delegated to other practitioners (physician assistant or nurse practitioner) who are credentialed through the BHS Medical Staff as a Allied Health Professional and in accordance with State law and hospital policy; however, the attending physician must sign the H&P and, as applicable, the update note and assume full responsibility for the H&P.

- Entry Errors
Entry errors anywhere in the medical record shall be corrected according to the following procedure:
1. The person who made the incorrect recording will be responsible for correcting the error.
2. The incorrect entry in the electronic medical record shall be edited by the recommended chart documentation procedure.
3. Incorrect paper chart entry shall be crossed out with a single line. The correct information shall be either above or below the entry error. The
originator shall initial the correction and enter the time and date the correction was made.
4. Mistakes in the medical record shall not be erased or obliterated. Use of correction fluid is not permitted in the paper portion of the medical record.

Section 7.04 Progress Notes

Progress notes sufficient to permit continuity of care shall be recorded by the responsible attending, consulting or physician on call for that service. Progress notes shall be entered into the electronic medical record at a minimum as stated in Section 1.04 of this document.

Section 7.05 Discharge Summary

A discharge summary shall be entered into the electronic medical record, or dictated for all inpatients, for patients hospitalized more than twenty-four (24) hours, and for all deceased patients regardless of the duration of hospitalization. The discharge summary shall include the medical problem that led to hospitalization; final diagnosis (primary and secondary); brief hospital course; the patient’s condition at discharge; discharge destination; reference to medical reconciliation; significant findings and test results; procedures performed; and the instructions given to the patient and/or family on discharge to include follow up appointments, anticipated problems, pending lab work and studies, recommended sub-specialty consults, and patient education. The discharge summary shall be completed as soon as possible following discharge but no later than fourteen (14) days following discharge. The discharge summary shall be authenticated within 48 hours following completion.

A final progress note may serve as the discharge summary in the following cases:

- Normal newborn records with uncomplicated deliveries
- Maternal records with uncomplicated deliveries with a hospital stay of less than 2 overnight stays

The final progress note as entered into the electronic medical record must contain sufficient information to document the diagnosis, evaluation and treatment received by the patient, and discharge instructions given to the patient and/or family.

Section 7.06 Symbols and Abbreviations

Baptist Health System utilizes the abbreviations listed in Stedman’s. Stedman’s is located on the BHS Intranet. All members of the medical staff must adhere to the requirement that they do not use non-approved abbreviations. The following abbreviations are considered by The Joint Commission to be unsafe for patient care and therefore have placed them on the Do Not Use Abbreviation List.
a. U (for Unit) – Practitioner must write out units.
b. IU (For International Unit) – Practitioner should write international unit or 10 (ten)
c. QD – Practitioner should write “daily” or “every other day”.
d. MS, MS04, MGS04 – Practitioner should write “Morphine Sulfate” or “Magnesium Sulfate”
e. Trailing Zero (X.0 mg) Lack of leading zero – Practitioner should never write zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.Xmg)

Section 7.07 Authentication

As the electronic medical record is the repository entity reflecting the care provided to patients in the Baptist Health system, all medical record entries will be legible, complete, dated, timed and electronically signed by the responsible practitioner at the time of entry or as in Section 4.03 and 4.04 of this document. To help ensure that the record is complete, accurate and final, before authenticating a dictation, blanks shall be filled in and substantive typographical errors corrected. In the few associated paper records attached to the patient’s chart and when in downtime paper charting, all medical record entries shall be legible, complete, dated, timed and signed by the responsible practitioner at the time of entry. To assist with identification of practitioner, a printed name and physician number accompanies the signature for any paper records.

The use of a rubber stamp with the physician’s name to facilitate legibility and prompt the inclusion of a time and date is allowed, however all signatures in the chart must be original. Electronic authentication via an EMR is considered equivalent to an original signature and will be accepted as such. CMS will not accept stamped signatures. The physician’s original signature must accompany any paper chart documents that require such an entry. There shall be no delegation of stamps or authentication codes to another individual.

Members may sign/authenticate medical records for another member of the physician’s group or another member of the medical staff with responsibility for the patient.

Medical staff members may sign/authenticate telephone orders for other physicians who are not in their practice group.

Medical Staff Members will respond to queries from Health Information Management within 48 hours.

Section 7.08 Completion of Medical Records

The attending/admitting practitioner and consulting practitioner shall complete the medical record of a discharged patient within 14 days after discharge. Failure to
complete a medical record within the prescribed time frame shall result in the practitioner having admission privileges restricted in accordance with these Rules and Regulations and Policies approved by the MEB and the Board.

Auto-authentication, whereby a physician signs one document to “authenticate” all missing signatures, is not acceptable.

Each entry in the chart must be authenticated with the Physician’s signature, physician number and date/time of signature when utilizing paper documentation during EMR downtime procedures for chart completion.

No medical record shall be filed in the permanent file until it is complete except by approval of MEB.

Section 7.09 Administrative Suspension and Revocation of Medical Staff Membership for Delinquent Medical Records

As directed by the BHS Medical Executive Board (MEB), the Health Information Management (HIM) Department shall review practitioner completion of medical records on a two week cycle. It is the expectation set by the MEB that all clinicians complete their medical records as soon as possible. At a minimum, clearing ALL incomplete records at least once every two weeks will keep each practitioner in good standing and will negate any process of administrative suspension described below. In the event a medical record is not complete (including authentication) within the thirty (30) days after discharge, the record shall be declared delinquent. To assist the MEB in timely stewardship of medical record completion by the BHS Medical Staff, the following practitioner dependent procedure will be followed.

1. Clinicians not having cleared all of their medical records within a two week period will be alerted by HIM of incomplete and delinquent medical records found at the time of the two week HIM review cycle and sent a notification of the need to complete their records; this will be entitled “First Notice”.

2. If this same practitioner is identified again at the time of the succeeding HIM review cycle two weeks later to have not cleared ALL incomplete medical records at least once during the two week cycle, then a notification entitled “Second and Final Notice” will be sent to the clinician. This notice will include a potential administrative suspension date approximately two weeks later to coincide with the next HIM review cycle.

3. If this same practitioner is identified again at the time of the succeeding HIM review cycle two weeks later to have not cleared ALL incomplete medical records at least once during the two week cycle, then the clinician is administratively
suspended without further notice. This administrative suspension entails the loss of physician’s privileges for elective procedures and elective admissions until all delinquent and incomplete records are completed whereupon the administrative suspension will be terminated.

4. Administrative suspension for delinquent records shall not excuse the Member from duties as previously assigned on the Emergency Department call roster. The Member may continue to care for patients already in the hospital or documented emergency cases, which require admission during the time of suspension.

5. Repeated delinquencies of medical records are grounds for corrective action and may be the basis for administrative revocation of medical staff privileges. Once a physician receives three (3) “Second and Final Notice” notification of delinquent records, they will be asked to attend the MEB meeting to explain why they are unable to comply with the Baptist Health System Medical Staff Rules and Regulations. If in any consecutive twelve (12) month period, a member of the medical staff receives five (5) “Second and Final Notice” letters for delinquent medical records, or fails to complete the delinquent medical records within two (2) months after being and remaining on administrative suspension status, then Medical Staff member will automatically lose all clinical privileges and BHS Medical Staff membership will be administratively revoked. This is not a reportable event and does not trigger a Fair Hearing.

6. Appeals for special circumstances will be directed to the BHS Chief Medical Officer.

7. A practitioner who has had his/her appointment or clinical privileges administratively revoked for failure to maintain and complete medical records will be required to reapply under the initial application process to include paying a fine of $300.00. The Category 2 application will not qualify for an expedited review and approval process and there are not provisions for temporary privileges. This is also not a reportable event and does not trigger a Fair Hearing.
Section 7.10    Discharge Instructions

The medical record shall indicate when printed instructions are given to the patient or family.

Section 7.11    Medical Records and Peer Review

Medical records will be audited for compliance with required elements as outlined in this document. These audits will be a routine component of Peer Review. The results will be shared with the supervising appropriate Medical Staff Department—Peer Review Committee, System Medical Staff Quality/Peer Review Committee, Professional Standards Committee, the Medical Executive Board and individual practitioners. Providers identified as not being compliant with required elements will be considered for administrative suspension after a staged remediation process to include committee letters, re-training and provider appearance before supervising medical staff committees named above.

Section 7.12    Electronic Medical Record Downtime Procedures

When the electronic medical record is not available for use due to hospital technical issues, either scheduled or unscheduled, the medical staff will follow downtime procedures for all medical record functions as per downtime policies. All written entries in the downtime paper medical records shall be legible, dated, timed and signed by responsible provider.

Section 8.00    House Staff and Medical Student(s)

Section 8.01    Medical Staff Status

Residents and fellows are not eligible for appointment to the Medical Staff and shall not be granted specific clinical privileges. House Staff shall be governed by Policy developed by the Education Committee and MEB and approved by the Board outlining responsibilities, obligations and limitations as to services House Staff may provide in the System.
Section 8.02 Independent Fellowship

Independent residents or fellows (foreign trained or otherwise) that are not associated with an Accredited Training Program may be approved for a specific period of time in the Baptist Health System to participate in activities as approved by the facility Medical Executive Committee, Credentials Committee, Medical Executive Board and Board of Trustees and as permitted by State Law.

For purposes of approval, these individuals shall submit a completed application to the Medical Staff Services Office, which will be approved by the Chief of Staff at the designated facility with activities subject to guidelines adopted by the Medical Executive Board.

Independent fellows (or residents) shall not be Members of the Medical Staff, but and shall be approved for the period of the approved fellowship. Activities shall be governed by Policy adopted by the Education Committee and MEB and approved by the Board and the individual agreement with the fellow and Medical Staff sponsor. As there is no accredited training program involved, these fellows shall be granted specific privileges according to their level of training and experience. Independent fellows shall meet all of the requirements for medical staff membership at all times.

The Medical Staff member sponsoring the individual shall provide evidence of liability insurance for supervision of the individual and shall be responsible for the activities of the individual within the Baptist Health System at all times. The individuals shall provide evidence of liability insurance in the amount approved by the facility MEC, Credentials Committee, MEB, and Board.

Section 8.03 House Staff Activities

Residents from accredited training programs (House Staff) shall not be considered Independent Practitioners, shall not be eligible for clinical privileges or medical staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under the Fair Hearing Plan. House staff shall be credentialed-certified by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing-certifying information shall be made available to the Hospital upon request and as needed by the Medical Staff Services Department in making any training assignments and in the performance of their supervisory function. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a House Staff Practitioner to provide services in the Hospital. House Staff may participate in the care of System patients under the supervision of credentialed Members of the Medical Staff per affiliation agreements between the involved institutions and the System.
House Staff shall be represented to patients at all times as being a practitioner in training. The supervising medical staff member prior to the House Staff performing or participating in any patient care activity shall obtain consent for any patient care activity performed by the House Staff.

The supervising Medical Staff Members shall notify their insurance carrier of participation in this activity and furnish evidence of coverage for this activity (supervision) to the Medical Staff Services Department.

The competence of House Staff shall be evaluated by supervising Medical Staff Members as required by the affiliation agreement. The affiliated institution, through its Residency Program Director, shall furnish and maintain the record of these evaluations.

Performance of all activities shall be in accordance with established System Policy.

Personal information regarding the House Staff assigned to the System shall be submitted to the Medical Staff Services Department and approved by the system Credentials committee. This will include documentation of:

1. A written affiliation agreement between the Hospital and the sponsoring medical school or training program.
2. Current Texas license or institutional license.
3. Professional liability coverage as required by the affiliation agreement and the Board.
4. Narcotics licenses (DEA & DPS).
5. Reports of any prior disciplinary action regarding professional matters.
6. Health testing as required by state or federal regulations.
7. Statement of competency.

A file shall be maintained by the Medical Staff Services Department containing the data above and the supervising Member’s participation agreement.

The House Staff will be provided with the following electronic medical record access.

Unless otherwise instructed by the supervising Member, House Staff shall be permitted with supervision to:

1. Perform and document admission histories and physicals in the electronic medical record, which shall be countersigned by the supervising Member within 24 hours of the patient’s admission.
2. Document in the electronic medical record progress notes. These entries shall be countersigned by the supervising Member within 48 hours.
3. Enter patient care orders in the electronic medical record under the supervision of the Member. The supervising Member shall countersign orders within 48 hours. The Member is responsible to determine the extent of supervision required of the House Staff to write orders.
4. Dictate procedure notes for cases that they have directly participated in, which
shall be countersigned by the supervising Member within 48 hours.

5. Dictate discharge summaries for patients whose care they have directly participated in, which shall be countersigned by the supervising Member within 14 days of discharge.

6. Scrub and assist as first assist.

7. Participate with the supervising Member in the clinical evaluation of patients (Emergency Department evaluation, inpatient evaluation, etc.).

House Staff shall not:

1. Serve as the primary surgeon.

2. Provide independent patient care.

Section 8.04 Medical Students in the OR

1. Third and Fourth year Medical Students will be allowed to scrub in on surgical cases and do tasks as prescribed under the attending physician’s direction as long as the following applies:

2. There is a signed Memorandum of understanding from the medical school and verification that the student has liability coverage and is in good standing.

3. There is an attending physician, who is affiliated with the medical school or who has a formal relationship with the medical school that allows him/her to be responsible for the medical student.

4. The attending is a member of the BHS medical staff in good standing.

5. The medical student must have appropriate identification issued by the Operating Room Director, and the Medical Staff Services department is made aware of the student and the length of time they will be spending with the attending physician.

Section 8.05 Non-Physician Practitioner (NPP)

The Non-Physician Practitioner (NPP) role is defined by the medical staff as active or affiliate. Active NNP’s may care for patients within the Baptist Health System under a collaborative agreement with an active member of the medical staff. The Affiliate NNP is intended for practitioners who do not admit or treat patients at the hospital but who request medical staff privileges for purposes of maintaining a continuity of care for the patient, participating in continuing education and meeting the requirements of third party payers for hospital affiliation. The Non-Physician Practitioner may have a collaborative agreement with an Affiliate physician.

1. NPP’s may write patient status orders (admitting orders) without a co-signature by the attending physician. The attending physician must evaluate the patient within a 24 hour period.

2. Perform and document history and physical examination on new patients in the electronic medical record. NPP’s do not have admitting privileges and patients...
are admitted under attending physician. Attending physician must evaluate patient within 24 hour period and co-sign admission and discharge summaries.

- Perform rounds and document progress notes on established patients in the electronic medical record.

- Progress notes do not require co-signature. The NPP is expected to communicate status update to attending physician as clinically appropriate.

- Provide discharge education, reconcile medications, prescribe medications upon discharge as needed, and document discharge summaries.

- Order invasive and non-invasive diagnostic studies and treatments

- Order consults for allied health services (e.g., PT, dietary) and specialists

- May sign inpatient restraint orders as appropriate for patient safety.

- May not sign death certificates but they can declare a patient deceased (pronounce) and annotate time of death on medical record.

Delegation of Prescriptive Authority & Other Medical Acts:

1. After delegated prescriptive authority has been established with the TMB, and in accordance with all applicable laws, the NPP may establish medical diagnoses for patients that are within his/her scope of practice, and enter electronic order or prescribe legend drugs and medical devices as authorized by the Texas BON under Rules 221 and 222, the TMB under Rules 193.2 and 193.6, and SB 406.

2. Controlled Substances: The NPP may enter electronic orders for and prescribe all categories of drugs, including Controlled Substances III – V providing the NPP has a DEA certificate and DPS permit. When prescribing drugs, generic substitution for all drugs is permitted and up to six refills for non-controlled drugs are permitted except birth control may be 11 refills.
   a. When prescribing controlled substances, the NPP is limited to prescribing no more than a 30-day supply and refills are not permitted unless authorized by the delegating physician
   b. The NPP shall not prescribe controlled substances for children under two years of age without prior consultation with the physician
   c. According to SB 406, NPPs may direct the hospital pharmacy to dispense controlled substances, Schedule II, for administration to in-patients or for patients being treated in the emergency room.

Recommended medications and dosages are listed below.

- Hydrocodone (all strengths and combinations) PO every 4-6 hours
- Hydromorphone 0.25-4 mg PO/PR/SC/IM/IV every 2-4 hours
- Meperidine 25-100 mg PO/IM/IV/SC every 4-6 hours
- Morphine sulfate 1-6 mg IM/IV/SC every 2-4 hours and 1-10 mg/hr IV infusion for comfort care patients (end of life)
- Morphine sulfate 10-30 mg PO every 4-6 hours
- Fentanyl 12.5-100 mcg IV/IM every 2-4 hours and 12.5-100 mcg/hr IV infusion for ICU sedation/analgesia
Oxycodone 5-30 mg PO every 4-6 hours

d. Special Considerations: Upon completing adequate training and credentialing as established by hospital policy, NPPs working in critical care units may use induction agents such as propofol, etomidate, and midazolam for intubations as authorized by delegating physician(s). Additionally, NPPs working in critical care units may order medications such as propofol, midazolam, and dexmedetomidine as continuous infusion sedation for intubated patients. NPPs are discouraged from using paralytic agents for rapid sequence intubation. However, in emergent situations where it is medically necessary, the NPP may use a short acting muscle relaxant such as succinylcholine and rocuronium and notify the attending physician as soon as possible. NPPs are authorized to sign hypothermia protocol order sets which include a paralytic as part of the order set.

e. Dangerous Drugs: The NPP may enter electronic orders for dangerous drugs, defined as drugs that can only be dispensed with a prescription from a licensed practitioner. Drugs or categories of drugs that may not be prescribed: Chemotherapy, investigational, radiological, and research.

f. Drug Samples: The NPP may request, accept, sign for, and distribute prescription drug samples. The NPP must maintain a record of distribution that includes the date of distribution, the patient's name, the name and strength of the drug and directions for use in accordance with applicable laws and regulations.

g. Procedures: NPPs are authorized to perform procedures within their scope of practice and as authorized by the hospital system and under the authority and responsibility of the sponsoring or collaborating physician. In order for the NPP to perform routine inpatient procedures (such as central lines and intubations) the NPP must:

a. Ensure procedure is within his/her scope of practice, as well as of the sponsoring physician.

b. Demonstrate competency and/or provide documentation of training

Section 9.00 Therapeutic Abortions and Sterilization

Section 9.01 Therapeutic Abortions

Purpose: In keeping with the ethics and values of the Baptist General Convention of Texas (Texas Baptists), the Baptist Health System does not provide elective non-therapeutic abortions. This chapter prescribes describes the process whereby we can ensure we hold our value and commitment to Texas Baptists while providing necessary medical care. A therapeutic abortion is a medically necessary intervention by which in the best medical judgment, the life of the baby will end as a result. In accordance with State law, even therapeutic abortions at and beyond 20 weeks of gestational age are severely restricted. This process meets the requirements of the law.

Guidelines for Therapeutic abortions to be considered shall be as follows:
1) A procedure for abortion may be performed prior to viability of a fetus by qualified, credentialed physicians, subject to meeting the following criteria:

   a) When continuation of the pregnancy in a physician’s reasonable judgment, so complicates the medical condition of a patient that ending the pregnancy is medically necessary to avert the patient’s death or a serious risk of substantial and irreversible physical impairment of a major bodily function, other than a psychological condition, OR 
   b) When the pregnancy has resulted from rape or incest, prior to 20 week gestational age OR 
   c) When there is a severe fetal abnormality which is incompatible with life. A severe fetal abnormality means a life threatening physical condition that, in reasonable medical judgment, regardless of the provision of a life saving medical treatment is incompatible with life outside the womb. 
   d) Ruptured membranes in the presence of intrauterine infection does not require application of this policy.

2) A request to perform a therapeutic abortion prior to viability of the fetus shall be made by the attending physician to the facility MEC’s Obstetrics and Gynecology Clinical Service Representative (Chief of Service) and will include the following:

   a) Summary of the medical history 
   b) Findings of the physical examination 
   c) Laboratory findings 
   d) Reason for requesting an abortion with or without sterilization 
   e) Written statements affirming that the request meets at least one of the above criteria by one obstetrical consultant or Material Fetal Medicine specialist. 
   f) In the absence of an OB-GYN Chief of Service, the MEC Chief of Staff or the designated alternate MEC leader shall be notified and statement e) will read “at least two obstetrical consultants or MFM’s”.]

3) Committee review of the request for a therapeutic abortion shall be given as follows:

   a) The OB-GYN Chief of Service of Chief of Staff shall appoint an ad hoc committee consisting of two (2) qualified physicians with credentials in obstetrics, and the Director of Pastoral Care or Staff Chaplain serving the facility involved to evaluate each request for therapeutic abortion. The attending physician shall not be appointed to the Committee. 
   b) Each member of the committee shall examine the application independently and submit a signed, written recommendation to approve or deny the procedure to the physician who appointed the committee. 
   c) The Chief of OB/GYN or the Chief of Staff who appointed the committee shall notify the patient’s attending OB of the decision of the committee.
4) For approved procedures, a signed and witnessed consent for the procedure from the patient or his/her legal representative shall be obtained by the attending physician.

5) In the case of an emergency, the Chief of Service or Chief of Staff or their designated alternates may give approval for the procedure after the request is received and reviewed by the MEC’s OB-GYN Clinical Service Representative, in consultation with the facility President and Director of Pastoral Care.

Section 9.02 Sterilization

Specific consent as required by State or Federal law shall be properly executed prior to any sterilization procedure.

Section 10.00 Autopsies

Each member of the Medical Staff is encouraged to actively participate in securing autopsies. Autopsies shall be performed by the Hospital Pathologist, or designee, and shall not be done without a proper written or telephone consent unless otherwise permitted by law. Attendance at autopsies is encouraged and the facility Pathologist shall notify the attending practitioner of the time of the autopsy and post notices of scheduled autopsies whenever possible.

Physicians are particularly requested to secure autopsies in cases where:

1. The cause of death is uncertain.
2. The underlying diagnosis is uncertain.

In accordance with Texas Law, cases that are required to be referred to the County Medical Examiner will be referred and the performance of an autopsy shall be covered by applicable law. Determination of whether a death meets the criteria and the results of the request for an autopsy shall be made by the Medical Staff member according to System policy.

Data on autopsies will be maintained according to policy.

Section 11.00 Recovery and Special Care Units

Section 11.01 Recovery Room
A patient receiving a general anesthetic (analgesia) shall go from surgery to the Recovery Room until dismissed by the anesthesiologist or dismissed in accord with Policy approved by the Anesthesia Clinical Service and the MEB.

A patient receiving a local anesthetic shall not be admitted to a Recovery Room unless there is a specific problem noted and request for admission made by a practitioner.

**Section 11.02 Special Care Units**

Upon request by the surgeon, a patient may be transferred directly from surgery to an Intensive Special Care Unit. While in surgery, should the decision to transfer the patient directly to a Special Care Unit be made, nursing staff shall be notified and will arrange for the transfer. This will be allowed when competent staff is available and when the same level of care can be provided as those that are recovered in the PACU. The surgeon should inform the patient’s family of the action.

**Section 11.03 eICU**

Levels of intervention by the eICU® clinicians in routine and emergent care of the patients being monitored is designated by selection of physician categories. The categories define the communication preferences of the ICU physician and the types of interventions permitted by the eICU clinicians without first contacting the managing physician team. All patients will be monitored by the eICU clinicians regardless of managing physician ‘category’. Physicians who do not choose a category for themselves are designated category II. All patients admitted to an ICU within BHS will be managed by the contracted intensivists covering the unit. Coverage at night will be carried out via the eICU. Non-contracted attending physicians may visit and give input on patients in the ICU, but they may not write orders. Special exceptions may be made with prior arrangement with the contracted intensivist for situations in which specialized care may be needed, such as specialized surgeries that may be beyond the purview of the contracted intensivist.

**Section 12.00 Emergency Department**

**Section 12.01 Appropriate Medical Screening Examination**

Any patient arriving at a Hospital emergency department shall be triaged according to the severity and nature of the illness/injury and afforded an appropriate medical screening examination (MSE) by the emergency department physician and/or a qualified Allied Health Personnel to determine if the patient has an emergency medical condition. If so, immediate diagnostic and treatment actions as necessary to stabilize shall occur within the resources available to the Emergency Department. The patient’s primary practitioner, if known and requested by the patient shall be notified as soon as possible. If a patient
does not have an emergency medical condition, the emergency department practitioner on
duty shall care for the patient as appropriate and determine the appropriate disposition.

A medical screening examination to determine if active labor or rupture of membranes is
present can be performed by qualified obstetrical nurses in accordance with established
policies and procedures.

Section 12.02 Specialty Consultation

If a patient requires care from a specialty consultant, the emergency department physician
shall contact the primary practitioner for appropriate instructions on the consultant to be
contacted unless the patient’s request is otherwise. It shall be the duty of the patient’s
primary practitioner to arrange for and contact desired consultants in a timely manner,
unless agreed upon by the Emergency Department provider. If the patient does not have
a primary practitioner or requests he/she not be contacted the emergency department
physician will use the consultant provided by the Medical Staff through the Emergency
Department call roster.

Each facility shall provide the emergency department with a call roster listing the
Members who will provide specialty services when they are needed. It will be the
responsibility of each facility MEC to maintain and enforce the call roster to ensure the
emergency department with adequate specialty coverage subject to MEB and Board
approval. If you are “on call” for the Baptist Health System ER and are unavailable for
any reason, you are responsible for getting alternative coverage. Coordination of these
activities shall be through the Medical Staff Services Office as agent. In the event of
questions regarding the ED call roster, the Chief of Staff shall be consulted to clarify the
situation.

The MEB shall evaluate and decide any question related to the ED call roster if
agreement cannot be reached at the facility level subject to approval by the Board. The
President of the MEB, in conjunction with the System Chief Executive Officer shall have
the authority to act if an immediate decision is needed related to any aspect of the call
roster.

The Emergency Department physician shall have the authority to request that the on call
practitioner come to the emergency department.

If the on call Member does not respond within 30 minutes by phone, or in an otherwise
appropriate and timely manner as determined by these Rules and Regulations, the matter
can be referred to the facility MEC for review. The issue can also be referred to the MEB
for corrective action after review by the facility MEC.

Section 12.03 Acceptance of Transfers
On call practitioners shall accept transfers of patients from other health care facilities who have an emergency medical condition which cannot be stabilized by the other health care facility if the on call practitioner and the Hospital have the capability and capacity to care for the patient.

Emergency Department physicians may not accept transfers for direct admission unless a Member with admitting privileges has agreed to accept the transfer and serve as the attending practitioner.

Members shall comply with Emergency Department and System Policy and appropriate State and Federal statutes in the provision of emergency services and patient transfers in or out of the System.

Section 13.00 Professional Liability Insurance

Each practitioner accorded clinical privileges for the System shall maintain in full force for the entire period of time the practitioner is a Member of the Medical Staff a professional liability policy of at least $100,000/$300,000 limits which shall cover the Member for all procedures, evaluations, treatments and supervision performed by the Member in the System. The policy shall be a regular occurrence policy or have a guaranteed tail or nose coverage for claims made policy to cover the entire period of time a practitioner has privileges.

Levels of insurance to be carried by practitioners under contract with the System shall be set forth in the governing contract and will be equal or higher than the above.

Levels of professional liability insurance to be carried shall be determined by the MEB and approved by the Board and may change from time to time.

Section 14.00 Infection Control

Section 14.01 Hand Hygiene

Current expectation, based on the Joint Commission and CDC best practices, is that Medical Staff is to perform Hand Hygiene.

a. Upon going into and exiting a room
b. Between dirty and clean tasks
c. Before donning PPE and after removal of PPE

Hand washing or alcohol sanitizers are both acceptable options except in the case of a patient with C. Dificile, in which hand washing is the appropriate option.
Section 14.02 Central Line Bundle

Based on IHI and the Joint Commission recommendations, all Medical Staff are expected to be in full compliance by using the 5 bundle components for central lines except, when doing so, would adversely affect the patient (i.e. code).

Section 14.03 Compliance with Isolation Precautions

Current expectations for PPE and patient isolation procedures are contained in policy IC-02. These policies include Standard Precautions. Standard Precautions combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and are intended for the care of all patients in all healthcare settings regardless of the suspected or confirmed presence of an infectious agent.

Section 14.04 Food or Drink in Patient Care Areas

In accordance with OSHA regulation 29CFR1910.141, Medical Staff is not to consume food or drink in patient care areas where exposure to pathogens or toxic material can lead to contamination.

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