

ARKANSAS CHILDREN'S HOSPITAL

RULES AND REGULATIONS OF THE MEDICAL STAFF

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1. ADMISSION AND DISCHARGE

1.1. Eligibility Criteria

1.1.1 The hospital is a pediatric facility with staff and employees specifically trained to care for the pediatric patient. Therefore, except as noted below, the hospital shall only accept inpatients, outpatients, and emergency patients who are under twenty-one years of age for care and treatment. The hospital shall not, however, regardless of age, accept obstetrical patients. Individuals with a psychiatric illness will be transferred to an appropriate facility or admitted with supervision, at the discretion of the Chief of Psychiatry or his designee, until transfer arrangements can be made.

Any exception to the age criteria will be made by the Senior Vice President for Clinical Affairs/Medical Director in concert with the clinical attending physician. Categories of exceptions include the following:

1.1.2 Categories of Exceptions for Persons Twenty-One Years of Age and older

1.1.2.1 The person requesting treatment and care is afflicted with a childhood illness for which the hospital has appropriate personnel and equipment to render special treatment and care required, such as muscular dystrophy, spina bifida, congenital heart disease, cystic fibrosis, cancer, hemophilia, other hereditary bleeding disorders, or sickle cell disease; and does not also have complicating adult disease processes for which appropriate expertise is not available at ACH.

1.1.2.2 The person requesting treatment requires the treatment and care available in the Burn Center; including reconstructive procedures.

1.1.3 Request for Exception

1.1.3.1 A request for inpatient admission to Arkansas Children's Hospital or to schedule a surgical procedure for a patient twenty-one years of age or over unless, being admitted to the Burn Service, must be submitted in writing to the Senior Vice President for Clinical Affairs/Medical Director prior to scheduling the admission. An exception may be made in the case of a bona fide emergency whereby approval for admission by the Senior Vice President for Clinical Affairs/Medical Director or his or her designee may be given pursuant to a request by telephone.

1.1.3.2 It is within the discretion of the Senior Vice President for Clinical Affairs/Medical Director whether or not to admit a person 21 years of age or over who do not meet the exception criteria. A request for admission may be forwarded by the Senior Vice President for Clinical Affairs/Medical Director to the Medical Staff Executive Committee for a decision. If admission to the hospital is denied by the Senior Vice President for Clinical Affairs/Medical Director, the clinical attending physician may submit the request in writing to the Medical Staff Executive Committee.

1.2 Admission Privileges/Responsibility for Care

1.2.1 Admission Privileges: A patient may be admitted to the hospital only by a member of the Active or Courtesy medical staff. In admitting patients, practitioners will follow the official admitting policies of the hospital. Administrative Policy B1 - Patient Admissions, Transfers, and Discharges

1.2.2 Medical Staff Responsibility: Although certain duties may be delegated to the house staff by the ACH medical staff member, the member of the medical staff is responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner. Whenever these responsibilities are transferred to another clinical service, an order covering the transfer of clinical service must be entered on the order sheet of the medical record.

1.2.3 Dentists and Oral & Maxillofacial Surgeons

1.2.3.1 A dentist with clinical privileges in pediatric dentistry or general dentistry with the concurrence of an appropriate physician member of the medical staff may initiate the procedure for admitting a patient. This concurring medical staff member assumes clinical attending responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for dental care must be given the same basic medical appraisal as patients admitted for other services.

1.2.3.2 An Oral & Maxillofacial Surgeon may admit patients, perform history and physical examinations, and perform procedures as outlined within his/her clinical privileges.

1.2.4 Assignment of Alternate Practitioners

1.2.4.1 Each practitioner must assure timely, adequate professional care for his/her patients in the hospital by being available or having available an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the hospital. Failure of the clinical attending physician to meet these requirements may result in loss of clinical privileges.

1.2.4.2 Each member of the staff who is not located in the immediate vicinity will name a member of the medical staff, who is a resident in the area and who may be called to attend his or her patients in an emergency, or until he or she arrives. In case of failure to name such an associate, the Chief Executive Officer/President, the Chief of Staff, or the chief of the service concerned will have authority to call any member of the active staff in such an event.

1.2.5 Emergency Admissions/Patient Assignment

1.2.5.1 A patient admitted on an emergency basis, who does not have an ACH staff member as a primary admitting physician, will be assigned to the attending physician in the applicable service. The chief of each service will provide a schedule of clinical attendings and housestaff.

1.2.5.2 Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In an emergency, such a statement shall be recorded as soon as possible.

1.3 Admission Priorities

1.3.1 Emergency Admissions: The clinical attending physician must provide to the Senior Vice President for Clinical Affairs/Medical Director sufficient information to justify the patient being admitted on an emergency basis. This may be in the form of the admitting history and physical examination and progress notes in the hospital record. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Staff Executive Committee for appropriate action.

1.3.2 Urgent Admissions: This category includes those so designated by the admitting physician and will be reviewed as necessary by the Senior Vice President for Clinical Affairs/Medical Director to determine priority when all such admissions for a specific day are not possible.

1.3.3 Prescheduled Admissions: This includes all patients who have been scheduled for admission. If it is not possible to handle all such admissions, the Senior Vice President for Clinical Affairs/Medical Director may decide the urgency of any specific admission.

1.3.4 Routine Admissions: This includes elective, unscheduled admissions involving all services.

1.4 Assignment of Beds During High Census: The admission of patients during periods of limited bed space availability shall be in accordance with Administrative Policy B-1 Patient Admissions, Transfers, and Discharges.

1.5 Areas of Restricted Bed Utilization: Areas of restricted bed utilization and preferred assignment of patients shall be defined within Administrative Policies approved jointly by administration and by medical staff.

1.5.1 All infants admitted to NICU will have an automatic consultation by the clinical attending neonatologist.

1.5.2 The Pediatric Intensivist designated by the Medical Director of the PICU will consult on all PICU Admissions.

1.6 Transfer Priorities

1.6.1 Priorities for transfer of patients shall be as follows:

1.6.1.1 Patients from any location to an intensive care bed.

1.6.1.2 Emergency Department patients, outpatients, and ambulatory surgery patients for emergency or urgent admission to a patient bed.

1.6.1.3 Patients with transfer orders from an intensive care bed to other locations in order to free an intensive care bed for emergency admissions.

1.6.1.4 Patients from temporary placement in a non-specialty unit to the appropriate specialty unit for the patient.

1.6.2 No patient will be transferred without such transfer being ordered by the patient's physician.

1.7 Discharge Responsibilities: Patients will be discharged only on a written order of the physician. Should a patient leave the hospital against advice of the practitioner or without proper discharge, the procedures for patients discharged against medical advice will be followed. The physician /dentist will write a discharge note in the patient's medical record stating that the patient left the hospital against medical advice (Administrative Policy B 3 Discharge Against Medical Advice).

2. GENERAL CONDUCT OF CARE

2.1 Consent (Administrative Policy K-1 Consent of Patient)

In accordance with administrative policy, a general consent form signed by, or on behalf of, every patient admitted to the hospital must be obtained at the time of admission. The admission office will notify the clinical attending physician whenever such consent has not been obtained. When so notified, it is, except in emergencies, the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

2.1.1. Informed Consent: In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of any risks inherent in any special treatment or surgical procedure will be obtained. It is the physician/dentist's responsibility to obtain the informed consent prior to special treatments or surgical procedures, except in cases of emergencies. Documentation of informed consent by use of the progress notes is encouraged. The physician shall inform the patient/family of any business or professional relationship to another health care provider or institution that might suggest a conflict of interest.

2.1.2 Administrative Consent: When immediate treatment is required to preserve life or prevent serious impairment of health, and it is impossible to obtain the patient's consent or that of someone authorized to consent on the patient's behalf, the physician may undertake the required procedure. Prior administrative approval should be obtained if possible.

It is not an emergency where delay would not materially increase the hazards, even though it is clear that the medical treatment in question will be needed. Whenever possible, a second physician's opinion should be obtained on whether or not an "emergency" exists.

2.2 Patient Assessment - Initial and/or Reassessment

2.2.1 Assessment: At the time of admission of a patient to an inpatient status, or within the course of patient contact in an outpatient setting (outpatient clinics, ambulatory surgery center, emergency department), an assessment of the patient's relevant physical, psychological, and social status and needs is made. For inpatients, the initial assessment and diagnosis shall be documented in the admission history and physical examination. For all outpatients, the assessment shall be recorded in the clinic or emergency department record. It is recognized that the nature and extent of this evaluation will vary among different clinical settings and be dependent upon the indication for the patient's contact with the physician.

2.2.2 Reassessment: A reassessment is performed and documented to determine the patient's response to treatment and when there is a significant change in the patient's condition or diagnosis. All patients (inpatients and outpatients) must be reassessed throughout the course of care at regular intervals depending upon the nature of the patient's illness and the setting of care. In the case of inpatients, the reassessment by the patient's physician or his/her designee should be documented in the progress notes. Transfer of patient, post-operative patients and discharge require a reassessment. Outpatient and

emergency department records should clearly indicate the timing and location of follow-up for reassessment.

2.3 Planning for Care of the Patient

2.3.1 Care, treatment, and rehabilitation are planned to ensure that they are appropriate to the patient's needs and severity of disease, condition, impairment, or disability.

2.3.2 Care is planned and provided in an interdisciplinary, collaborative manner. Documentation includes departmental reports, interdisciplinary conference notes, in the progress notes and other records.

2.4 Protection of Patients and Others: The clinical attending physician is responsible for giving such information as may be necessary to assure the protection of others whenever his or her patient might be a source of danger from any cause whatsoever.

2.4.1 Restraints (Administrative Policy J17 Restraints): When a patient needs protection to avoid injury to self and/or others, restraints may be used to immobilize or restrict activity.

2.4.1.1 For restraint use directed by the Medical Surgical Protocol: The MD shall be notified and involved in the decision to initiate the protocol for each patient. The physician's order to use the protocol shall be obtained within 12 hours of initiating the restraint. To initiate the use of restraints per protocol, the order should read: "Restrain per Medical Surgical Restraint Protocol"

If protocol criteria are not met, an order is required to initiate the use of restraints. Each order must be time limited not to exceed the maximum time limit of 24 hours and include type of restraint and clinical justification for restraint and specify any variation from this policy for monitoring and for release from restraints. PRN orders are not accepted. An order is required every 24 hours for continued justification of the restraint.

2.4.1.2 Restraint use for behavioral management: The physician must be notified immediately and the MD will conduct an in-person evaluation within 1 hour of restraint applied. The Behavioral Restraint MD Order form must be used. Orders for the use of the restraint must include date, time, type of restraint, reason for restraint, time limit and the criteria that must be achieved before restraints can be removed. Verbal or written orders are limited to 1 hour.

2.4.1.3 A new order will be required if:

- Same behaviors are evident, but a different intervention is needed.
- Different dangerous behaviors have emerged.
- The time limit has passed since the original order.

2.4.2 Suicide Precautions: For the protection of patients, the medical and nursing staffs, and the hospital, precautions to be taken in the care of the potentially suicidal patient will be according to Psychiatry Service/Policy and Procedures. (Administrative Policy B11 – Guidelines for Evaluating Patients with Identified Emotional, Psychiatric, or Substance Abuse Problems)

2.5 Orders

2.5.1 Written Order: All orders for treatment must be in writing. The practitioner's orders and signature must be written clearly, legibly, completely, and be dated and timed. The signature shall be followed by the appropriate designation, i.e. MD, PGYII, etc. Orders which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.

2.5.2 Telephone/Verbal Orders

2.5.2.1 Telephone/Verbal orders will be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the responsible practitioner or by any member of the healthcare team who is authorized to order the drug or therapy.

2.5.2.2 All telephone/verbal orders will be dated, timed, and signed by the appropriately authorized person to whom dictated, with the name of the practitioner per his or her own name and designation, i.e. RN, RT, etc..

2.5.2.3 Telephone/verbal orders shall be authenticated with signature and date within 30 days of discharge.

2.5.2.4 Telephone/verbal orders should be used infrequently.

2.5.2.5 Telephone/verbal orders for medications shall be given only to registered nurses (RNs) or pharmacists. Other professionals such as Physical Therapists, Respiratory Therapists may take telephone/verbal orders for patient treatments as they pertain to their field.

2.5.3 Requirements for Reviewing and Rewriting Orders: Physician's orders are to be reviewed and rewritten in the following instances:

2.5.3.1 On admission to or discharge from a special care area.

2.5.3.2 After surgical procedures performed in the operating room.

Exception: Rewriting of physician's orders is NOT required following minor surgical procedures such as line placement and endoscopy, if there is no change in the patient's condition. In this circumstance, an order to resume pre-operative orders is required. This order must specify either by time or by patient condition (e.g. alert) when the orders (medication, diet, etc) shall be resumed.

2.5.3.3 With changes in the service or physician responsibility.

2.5.3.4 At least once per month.

2.5.4 Standing Orders: Standing orders are not permitted.

2.5.5 Protocols, guidelines, and care plans: Protocols, guidelines, and care plans approved by the Medical Staff may be used if there is an order by the practitioner. These orders must be individualized to the patient.

2.6 Drugs and Medications

2.6.1 Formulary: It is preferable that drugs and medications administered to patients shall be those listed in the hospital's drug formulary. The Pharmacy and Therapeutics Committee is responsible for developing and revising the formulary.

2.6.2 Ordering Medications: Practitioners are encouraged to order medications by the non-proprietary or official names, instead of proprietary or trade names. Drugs shall be ordered in the metric system. Refer to these Rules and Regulations 3.4 for use of symbols and abbreviations.

2.6.3 Investigational Drugs: Drugs for bona fide clinical investigation may be exceptions and must be approved by the UAMS Human Research Advisory Committee on which ACH is represented.

2.7 Request for Consultation

2.7.1 Requesting Consultation: Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his or her area of expertise. The clinical attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He or she will provide written authorization to permit another practitioner to attend or examine his or her patient, except in an emergency.

2.7.2 Mandatory Consultation: Except in an emergency, consultation is required in the following situations:

2.7.2.1 In instances in which the patient exhibits attempted suicide.

2.7.2.2 When there is evidence to cause a suspicion of child abuse.

2.7.2.3 When requested by the patient or his or her family.

2.8 Patient and Family Education

2.8.1 As appropriate to care, the patient and family educational process is collaborative and interdisciplinary.

2.8.2 Medical staff shall participate in measuring, assessing, and improving the education of patients and families.

2.9 Review of Care: If any health care provider has concerns regarding the care provided to a patient, or believes that additional consultation is needed, he or she shall call this to the attention of his or her immediate supervisor who will evaluate and report appropriately.

2.10 Receipt of Patients After Major Disaster/Disaster Exercises

2.10.1 In the event of an external disaster in this geographic area, Arkansas Children's Hospital will likely be a recipient of affected infants, children and burn victims. Patients will be received in accordance with the External Disaster Plan. (Safety & Emergency Manual: External Disaster Policy)

2.10.2 The Medical Staff will participate in disaster preparedness exercises. A written report and evaluation of all such exercises shall be made to the Medical Staff Executive Committee.

2.11 Do Not Resuscitate: When a decision has been made not to resuscitate or to forego or withdraw medical treatment, the acceptable order by the physician is: Comfort Care. The Comfort Care Policy (J15) will be followed in reaching this decision and carrying out this order.

2.12 Hospital Deaths

2.12.1 In the event of a hospital death, including DOA, the deceased will be pronounced dead by the clinical attending physician, or his/her designee within a reasonable time. The body will not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff, or his designated houseofficer. Policies with respect to release of bodies will conform to local and state law.

2.12.2 Deaths Reported to the Coroner: ACH will comply with Arkansas law regarding reporting of deaths to the Pulaski County Coroner. Refer to Administrative Policy, J 14 – ACH Plan for Response to a Patient Death, Addendum A – The MD's Role

2.12.3 Autopsies: It is the duty of all practitioners to secure meaningful autopsies whenever possible. In all deaths the possibility of autopsy should be discussed with the family. An autopsy may be performed only with telephone or written consent, signed in accordance with state law, and Hospital Policy K 1 Consent of Patient. In all appropriate cases, organ or tissue procurement will be discussed. These discussions shall be documented in the medical record.

2.12.4 Deaths In Which Autopsy May Be Indicated: Each Chief of Service will develop guidelines regarding cases in which autopsies may be indicated. These guidelines will be approved by Medical Staff Executive Committee and disseminated to the medical staff. (Medical Staff Policy: Autopsy Guidelines)

2.12.5 Performance of Autopsy

2.12.5.1 Autopsies will be performed by pathologists, who are members of the ACH Medical Staff, or by a houseofficer delegated this responsibility and supervised by the attending

Pathologist. Provisional anatomic diagnoses will be recorded in the medical record within two working days, and the complete protocol should be made a part of the record within 60 working days.

2.12.5.2 Under certain conditions, deceased patients who expire outside of the hospital may be referred to the ACH morgue for autopsy. Refer to Administrative Policy J14: ACH Plan for Response to a Patient Death.

2.12.6 Autopsy Findings: It is the responsibility of the patient's clinical attending physician to assure that the family is informed of the autopsy findings.

2.13 Brain Death

2.13.1 Establishment of Guidelines: Guidelines for determination and documentation of patient death when circulatory and respiratory functions are being maintained by artificial means of support are established through policies and procedures recommended by the Intensive Care Committee.

2.13.2 Policies and Procedures: Policies and procedures regarding Brain Death Determination and Documentation are included in the administrative policy and procedure manual. (Administrative Policy K11 Brain Death Determination and Documentation)

2.13.3 Notification of Parent or Guardian: Prior to discontinuance of artificial support systems, the parent or guardian of the patient will be notified of the determination of brain death and of the specific tests performed in reaching that determination. Life support systems will be terminated by, or at the discretion of, the responsible physician.

2.14 Organ Recovery for Donation Program

2.14.1 Scope of the Program: The Organ Donation Program will be for donation of all currently transplantable organs and tissues and for donation of organs and tissues for research.

2.14.2 Responsibility for Coordination of the Program: Coordination of the Organ Donation Program is the responsibility of the Intensive Care Committee.

2.14.3 Program, Policies, and Procedures: The Organ Donation Program, as well as policies and procedures necessary to carry out the Program, will be presented to the Intensive Care Committee for review and recommendation to the Intensive Care Committee and submitted to the Medical Staff Executive Committee for approval. Administrative Policy K16: Routine Referral of Organ and Tissue Donation.

2.14.4 A quarterly report of organ and tissue donation shall be made to the Intensive Care Committee.

3. HEALTH INFORMATION MANAGEMENT

3.1 Content: The clinical attending physician is responsible for preparation of a complete and legible medical record for each patient. The contents must be pertinent and current. This record will include identification data; complaints; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; evidence of multidisciplinary patient and family education; final diagnosis; condition on discharge; summary or discharge note; and autopsy report, when performed.

3.1.1 History and Physical Examination: A complete admission history and physical examination will be recorded within 24 hours of admission. This report should include all pertinent findings resulting from the patient's history, an assessment of all body systems, diagnosis, and plan of care.

3.1.1.1 When using an H & P that was performed within 30 days before admission, a written update to the patient's condition is required at the time of admission or prior to the patient having surgery or procedures requiring anesthesia or sedation. When a H&P older than 24 hours is used, a legible copy of these reports must be placed in the patient's hospital medical record.

3.1.1.2 If the H&P has been written by a physician who is not a member of the ACH medical staff, the update at the time of admission must be by a member of the Medical Staff or other practitioner who has the privilege to do so.

3.1.1.3 When the history and physical examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the primary physician states in writing that such delay would be detrimental to the patient.

3.1.1.4 If a patient initially admitted as observation status but remains in the hospital for greater than 24 hours and if a limited H&P was performed at the time of admission to observation status, the physician should note the change of status in the progress notes and document additional information or findings necessary for a complete inpatient H&P.

3.1.1.5 The clinical attending physician will countersign the history, physical examination and discharge summary when they have been recorded by a member of the house staff or by an advanced practice nurse with appropriate privileges.

3.1.2. Progress Notes

3.1.2.1 Pertinent progress notes (staff or housestaff) will be recorded at the time of observation, sufficient to permit continuity of care and transfer.

3.1.2.2. Progress notes should include interdisciplinary planning of care. Observations pertinent to the chronology of the patient's hospital stay may be recorded in the progress notes section of the medical record by the following: Medical Students, Respiratory Therapy, Clinical Nutrition, Social Work, Child Life, Discharge Planning, Rehabilitation Services, EEG, Pharmacy, Pharmacokinetics, and members of the Affiliated Health Professional Staff and shall reflect interdisciplinary planning of care. Nurses may document progress of patients on the Progressive Care Rehabilitation Unit in the Progress Notes.

3.1.2.3 Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

3.1.2.4 Progress notes must be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

3.1.3 Operative Report

3.1.3.1 Operative Reports are required for operative procedures and the following categories of invasive procedures:

- (1) Bronchoscopies, endoscopies (including G.I. biopsies)
- (2) Percutaneous biopsies (renal and liver)

3.1.3.2 Operative reports must include the name of the primary surgeon and assistants, postoperative diagnosis, details of the surgical technique, specimens removed, and findings at surgery. Operative reports will be written or dictated promptly following surgery for outpatients as well as inpatients, and promptly e-signed or manually signed by the surgeon and made a part of the patient's current medical record. A written progress note documenting the surgery is entered immediately to provide for continuity of care until the dictated operative report has been transcribed. While it is the expectation that the practitioner will dictate the operative report immediately following surgery, if he/she fails to do so, the practitioner will be automatically suspended from operative privileges except for any inpatients, who already have been scheduled for surgery. When such delinquency is noted, it shall be brought to the attention of the practitioner and the appropriate Chief of Service and when necessary, to the Medical Staff Executive Committee.

3.1.4 Catheterization Reports

3.1.4.1 Catheterization reports must be completed on every patient following cardiac catheterization. A handwritten note describing the cardiac catheterization procedure and the preliminary results must be placed on the chart immediately following the procedure. A report will be dictated within 72 hours following the procedure. The final typed report of the catheterization will include:

- a) A paragraph summarizing the clinical findings to include pertinent history, physical findings, non-invasive cardiac diagnostic findings and the reason for catheterization.
- b) A description of the technical aspects of the procedure.
- c) A discussion of the physiologic measurements recorded at catheterization and a discussion of the angiographic findings.
- d) A conclusion summarizing the data with a complete analysis of the cardiac anatomy and physiology.

e) Recommendations for subsequent treatment, including possible surgical interventions, medical treatment, and follow-up.

3.1.4.2 Reports of cardiac biopsies are completed on a handwritten form and will meet the requirements for reports of invasive procedures.

3.1.5 Consult Notes: Consultations will show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report will be made a part of the patient's record. A limited statement, such as "I concur," does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note must be recorded prior to the operation except in emergencies.

3.1.6 Discharge Documentation

3.1.6.1 The final progress note shall include an assessment of the patient and his/her condition at time of discharge.

3.1.6.2 A comprehensive discharge summary will be written or dictated for all patients hospitalized over 48 hours.

3.1.6.3 Whether written or dictated, the content of the discharge summary must be sufficient to justify the diagnosis and warrant the treatment and result.

3.1.6.4 A written Discharge Summary Note (family take home instructions), a copy of which is given to the parents, may be used in place of a dictated discharge summary for patients who had an admission of 48 hours or less, the potential for complication was low, and the anticipated outcome was predictable and likely. Medications, care at home, follow-up appointments and plans shall be documented on the written Discharge Note given to the parent.

3.1.6.5 The final physician order may read "Discharge patient home. See written discharge summary sheet for instructions."

3.1.6.6 Summaries must be signed by the clinical attending physician.

3.1.7 Recording Final Diagnosis: The final diagnosis must be recorded in full without the use of symbols and abbreviations, dated, and signed by the responsible practitioner at the time of discharge of all patients.

3.2 Clinical Entries

3.2.1 All clinical entries in the patient's medical record will be accurately dated, and authorship established by electronic or written legible signature.

3.2.2 Health Care providers' signatures within the medical record shall be followed by the appropriate designation: i.e. M.D. PGY II, MS4, RN, RT, etc.

3.3 Rubber Stamps: The use of rubber stamp signatures is permitted under the following conditions:

3.3.1 The practitioner whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; and

3.3.2 The practitioner places in the designated office of the hospital a signed statement specifying that he or she is the only one who has the stamp, and the only one who may use it.

3.4 Symbols and Abbreviations (Administrative Policy J-32 Documentation)

3.4.1 Abbreviations are not acceptable in the final diagnosis, on consent forms, or in any information given to patients/families, such as the educational materials or the Discharge Summary Sheet.

3.4.2 Abbreviations for medications are discouraged. Unacceptable abbreviations that make an order unclear will be clarified with the prescriber as part of routine pharmacist order intervention and clarification.

3.4.3. Some abbreviations are considered dangerous for patient safety and should not be used. Refer to Administrative Policy J-32 for a list of unapproved abbreviations.

3.5. Release of Medical Information: Written consent of the patient or legal guardian is required for release of medical information to persons not otherwise authorized to receive this information.

3.5.1 Request for Records: Physicians may request medical records in accordance with Administrative Policy J8, Request for Medical Record.

3.5.2 Removal of Records: Records with protected health information may be removed from the hospital's jurisdiction and safekeeping in accordance with administrative policy on protected health information. All records are the property of the hospital and may not be removed without permission of the Chief Executive Officer/President or Senior Vice President for Clinical Affairs/Medical Director). In case of readmission of the patient, all previous records will be available for the use of the practitioner. This applies whether the patient is attended by the same practitioner or another. Unauthorized removal of original patient medical records from the hospital is reason for suspension of the practitioner or housestaff member for a period to be determined by the Medical Staff Executive Committee.

3.5.3 Access to Records

3.5.3.1 On submission of an Institutional Review Board (IRB) approved research protocol to the Director of Health Information Management Department, access to pertinent medical records of

patients may be afforded to the member of the medical staff (principal investigator) for research consistent with preserving confidentiality.

3.5.3.2 Subject to the discretion of the Chief Executive Officer/President, former members of the medical staff may be permitted access to information from the medical records of their patients covering periods of time during which they attended such patients in the hospital.

3.6 Confidentiality of Patient Information Obtained Via the Hospital Information System:

Patient-identifiable information obtained through the hospital information system is confidential and subject to all rules and regulations pertaining to permanent medical records. Inappropriate use of confidential patient information including unauthorized access to the hospital information system, may be grounds for corrective action in accordance with the Medical Staff Bylaws.

3.7 Medical Record Completion

3.7.1 The patient's medical record should be complete at the time of discharge, including history and physical, operative reports, progress notes, final diagnosis, and a dictated or written clinical summary. When this is not possible at the time of discharge, the patient's chart will be maintained by the Health Information Management Department. A medical record will be declared delinquent by the Health Information Management Department if it remains incomplete thirty (30) days after discharge. Physicians shall complete all available incomplete records when requesting inactive staff status.

3.7.2 Policies and procedures for notification of practitioners with incomplete and delinquent records and for actions to be taken for practitioners with delinquent records will be approved by the Medical Staff Executive Committee. Consistent failure to complete medical records may result in penalties up to and including suspension until records have been completed. (Also refer to UAMS Policy of the Graduate Medical Education Committee; Section: Resident Support/Conditions for Employment; Subject: Medical Records for responsibilities of the resident for completion of medical records in the major participating institutions.)

3.7.3 A medical record will not be permanently filed until it is completed by the responsible practitioner. Under certain circumstances, an incomplete record may be ordered filed by the Medical Records Committee (Information Management Committee). No medical staff member is permitted to complete a medical record on a patient unfamiliar to him or her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable permanently or protractedly for other reasons.

Definitions

Incomplete chart: Any chart of a discharged patient not containing proper chart structure, progress notes, clinical resume or final progress note, final diagnosis and complications, discharge plan, and a dictated discharge summary signed by the dictating houseofficer and attending staff physician.

Delinquent chart: Any incomplete chart not completed as above within thirty (30) days after discharge.

4. ADDITIONAL RULES AND REGULATIONS APPLICABLE TO SPECIFIC SERVICES

4.1 RULES REGARDING SURGICAL CARE:

4.1.1 General Considerations: The surgical operating suite is an area of specialized services integrated in the total care of the patient. In order to function efficiently, a rational schedule must be maintained. The operative schedule will not be manipulated solely for the convenience of those wishing to use the facility.

4.1.2 Scheduling Operations: Operations will be scheduled in accordance with Operating Room policies and procedures and as approved by the Surgical Affairs Committee.

4.1.3 Requirements Prior to Anesthesia and Operations

4.1.3.1 Identification of Patient: Positive identification of a patient may consist of an extremity band denoting the patient's name, age, birth date, and hospital number. At least two identifiers on the armband must be verified by another source, e.g. confirmation by parent, stamped information on the medical medical or consent form.

4.1.3.2 Preoperative Assessment and Documentation: Medical record content - A history and physical including diagnosis and perioperative plan, should be on every patient's chart prior to surgery. (Refer to 3.1.1-3.1.1.4 History and Physical Examination) For emergency cases, a concise, informative note with pertinent information as to the patient's age, physical condition, diagnosis, operative procedure contemplated and a note that the history and physical have been dictated will serve in lieu of a formal history and physical.

4.1.3.3 Diagnostic Procedures - Preoperative laboratory and X-ray examinations should be appropriate to the patient's condition, diagnosis and procedure. Any information brought into the hospital from a physician's office must include 2 identifiers that can be used to verify that the information belongs to the patient presenting for surgery.

4.1.3.4 Informed consent forms - The standard permit for surgery and anesthesia must be properly completed, witnessed and dated. A properly executed informed consent is valid for up to thirty (30) days prior to the surgical procedure. O.R. staff will confirm the consent on the day of the procedure and document confirmation in the patient's permanent record. Consent by telephone may be obtained by the physician who converses with the parent(s) or guardian(s). This telephone conversation must be witnessed by a hospital employee. (Administrative Policy K-1 Consent of Patient)

4.1.3.4.1 Should a second operation be required during the patient's stay in the hospital, a second consent specifically worded as to procedure should be obtained.

4.1.3.4.2 If two or more specific procedures are to be carried out at the same time and this is known in advance, all procedures must be described and consent obtained.

4.1.3.5 Incomplete Preoperative Evaluation or Documentation - Except in severe emergencies, the preoperative diagnosis of the patient and appropriate laboratory tests must be recorded on the patient's medical record prior to any surgical procedure or the procedure shall be canceled. In any such emergency, the practitioner shall make at least a comprehensive note regarding the patient's clinical status and the nature of the emergency procedure, anesthesia and start of the operation. When the history and physical examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be delayed, unless the primary physician states in writing that such delay would be detrimental to the patient.

4.1.4 Starting Time of Operations: Every effort should be made to adhere to the scheduled start time of operations. Flagrant or habitual violation will be reported to the Surgical Affairs Committee.

4.1.5 Operations - Dental Patients

4.1.5.1 Dental Patients may be scheduled as an inpatient or through Ambulatory Surgery by Dentists and Oral & Maxillofacial Surgeons. If the patient is followed by a subspecialist, the subspecialist shall be notified by the Dentist or Oral & Maxillofacial Surgeon that the dental surgery is planned and the date/time of the scheduled procedure.

4.1.5.2 Oral & Maxillofacial Surgeons have admitting privileges and do not require dual responsibility involving a physician member of the medical staff. The Surgeon is responsible for meeting all medical record requirements.

4.1.5.3 A patient scheduled for dental care by dentists with privileges in pediatric dentistry or general dentistry as either an inpatient or through Ambulatory Surgery is a dual responsibility involving the dentist and physician member of the medical staff.

4.1.5.4 Dentists' Responsibilities

- a) A detailed dental history justifying hospital admission and/or dental procedure to be performed.
- b) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
- c) A complete operative record, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.
- d) Progress notes as are pertinent to the oral condition.

A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the medical staff. At the time of admission, both the dentist and physician will be in the admission order.

4.1.5.5 Physicians' Responsibilities

- a) Medical history pertinent to the patient's general health.
- b) A physical examination to determine the patient's condition prior to anesthesia and operation.
- c) Supervision of the patient's general health status while hospitalized.

4.1.6 Surgical Procedures for Which a First Assistant is Required: A list of surgical procedures in which a first assistant is required, as delineated by each chief of a surgical service, will be approved by the Surgical Affairs Committee.

4.1.7 Outpatient Operations Requiring General Anesthesia

4.1.7.1 Arrangements: Arrangements for outpatient operations requiring general anesthesia are made through the Department of Anesthesiology and Ambulatory Surgery Center. Policies and procedures for ambulatory surgery scheduling and operation will be approved by the Surgical Affairs Committee.

4.1.7.2 Minimum Requirements:

- a. A consent for surgery or other procedure form shall be properly executed within one month prior to the operation.
- b. A history and physical, diagnosis, and perioperative plan should be on every patient's chart prior to surgery. (Refer to 3.1.1.1-3.1.1.4 History and Physical Examination) Documentation requirements for the history and physical examination include:
 - c. When the pre-anesthetic consult H&P is used as the preoperative H&P, the surgeon will perform and document an abbreviated H&P to include: history sufficient to justify the procedure, physical examination appropriate for the procedure, pre-operative diagnosis, and plan. This abbreviated H&P by the surgeon must be completed within 24 hours prior to the surgery or procedure.
 - d. For outpatient procedures, such as MRI and CTs, that require anesthesia/sedation, the H&P may be done by the physician administering anesthesia/ sedation.

e. Patients admitted following the surgical procedure shall have documentation consistent for admission and as required by Medical Staff Rules and Regulations and hospital policy.

4.1.8 Time Out Immediately Prior to the Start of Procedure: Immediately prior to the start of a procedure, the surgical team will perform a time out to assure the right patient, right procedure, and right site. Administrative Policy A19: Verification of Patient and Procedure.

4.1.9 Discharge From the PACU: Discharge from the post-anesthetic recovery area will be at the discretion of the Chief of Anesthesiology or designee.

4.1.10 Specimens to be Examined by Pathology: All appropriate specimens will be sent to the pathologist for examination. A list of specimens exempted from examination by pathology and specimens exempted from microscopic examination but requiring gross examination by Pathology will be recommended by the Surgical Affairs Committee and Chief of Pathology and presented for approval of the Medical Staff Executive Committee. (Medical Staff Policy: Specimens Exempt from Path

4.2 RULES REGARDING ANESTHESIA SERVICES

4.2.1 General Consideration: The standards for anesthesia care apply when patients in any setting receive, for any purpose, by any route, the following:

- o General anesthesia or other major regional anesthesia, such as spinal or epidural anesthesia (Refer to Anesthesia Department Policies)
- or
- o Moderate or deep sedation (with or without analgesia) that, in the manner used, may be reasonably expected to result in the loss of protective reflexes. (Refer to Administrative Policy I17: Use of Sedation or Analgesia During Procedures)

4.2.2 If a patient is to receive general anesthesia, other major regional anesthesia, or moderate or deep sedation, a practitioner with privileges to administer anesthesia or sedation shall perform a pre-anesthetic/sedation evaluation prior to the diagnostic or therapeutic procedure. For all instances of general anesthesia or moderate or deep sedation, the patient must be reassessed immediately prior to the administration of anesthesia or sedation.

4.2.3 With respect to inpatients following general, regional anesthesia, or moderate sedation, a postanesthesia/sedation evaluation must be completed and documented by an individual with privileges to administer anesthesia or sedation. The post anesthesia/sedation evaluation will be done after the patient finishes the recovery period and within 48 hours following the diagnostic or therapeutic procedure.

4.2.4 With respect to outpatients, a postanesthesia/sedation evaluation for proper anesthesia/sedation recovery is performed prior to discharge from the care setting and in accordance with policies and procedures approved by the medical staff.

4.3 EMERGENCY SERVICE

4.3.1 Physician Coverage of Emergency Room: A physician is on duty in the Emergency Department 24 hours per day. Specialty consultation is available within 30 minutes. Additional medical staff coverage is provided by houseofficers under the supervision of a member of the medical staff. A roster designating medical staff members on duty or on call for primary coverage and specialty consultation is available in the Emergency Department.

4.3.2 Notification of the Patient's Physician: Any member of the medical staff may provide care in the Emergency Department. When it is identified that the patient's primary care physician is a private practitioner and if he or she so desires, the practitioner should be notified at the earliest appropriate time that his or her patient has presented to the Emergency Department. If the practitioner chooses not to come to treat his or her patient, a report of the Emergency Department visit will be provided to the practitioner with the patient's consent.

4.3.3 Medical Screening Examinations: Determination of whether an individual who comes to the Emergency Department has an emergency medical condition shall be made by a physician. Medical screening examinations in remote clinical sites not routinely staffed by physicians will be conducted by a Registered Nurse, an Advanced Practice Nurse or a Registered Nurse Practitioner. If an emergency medical condition exists, the hospital will provide within the capabilities of the staff and facilities such further medical treatment or examination as is required to stabilize the patients. If it is not within the capabilities of the hospital staff and facilities to stabilize the emergency medical condition of the patient, the patient will be admitted or transferred to an appropriate facility in compliance with Emergency Medical Treatment and Active Labor Act of COBRA.

4.3.4 Policies and Procedures: Policies and procedures for the Emergency Department are the responsibility of the Medical Director of the Emergency Department with review by the Intensive Care Committee and approval by the Medical Staff Executive Committee. Included in these will be criteria for the triage when performed by someone other than a physician and the scope of treatment provided.

4.3.5 Emergency Log: The name of every patient seeking emergency care will be recorded on the Emergency Log and a disposition indicated. Based on established criteria, patients may be triaged to a more appropriate area to receive services.

4.3.6 Emergency Department Records

4.3.6.1 Contents of Emergency Department Records: Emergency Department records must contain at least the following information:

- a) Patient identification. When not obtainable, the reason must be entered and emergency identification procedures implemented;
- b) Time and means of arrival

- c) Pertinent history of illness or injury and physical findings, including vital signs
- d) Emergency care given the patient prior to arrival
- e) Diagnostic and therapeutic orders
- f) Clinical observations, including results of treatments
- g) Reports of procedures, tests, and results
- h) Diagnostic impression
- i) Conclusion at the termination evaluation/treatment, including final disposition, the patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care.

4.4 OBSTETRIC CARE: No obstetric care will be provided in this hospital, except in cases of emergency. Obstetric cases presenting with emergency medical conditions will be handled in accordance with applicable state or federal laws relating to transferring such patients.

4.5 OUTPATIENT CARE SERVICES

4.5.1 Standards for Patient Flow and Space Utilization :

4.5.1.1 In coordination with the respective clinic medical director, the Outpatient Medical Director, in collaboration with the appointed hospital administrator, shall be responsible for development of appropriate standards for each clinic in reference to patient flow and space utilization. A physician who fails to adhere to these standards will be counseled by the appropriate clinic medical director and, if necessary, the Outpatient Medical Director, in concert with the respective service chief who will be ultimately responsible for insuring that the standards are met.

4.5.1.2 Clinic space will be provided based upon availability, patient volume, and utilization of allocated space. Hospital based physicians will have priority for scheduling and space. Community physicians may participate in ACH sponsored clinics at the discretion of the chief of service as needs dictate. The clinic medical director will work closely with the appointed hospital administrator to supervise and organize clinic personnel.

4.5.2 Policies and Procedures: Policies and Procedures and Outpatient Care Standards for Outpatient Care will be reviewed by the Outpatient Care Committee, submitted to Patient Care Committee for quality improvement, and forwarded to the Medical Staff Executive Committee for approval.

4.5.3. Clinic Activities/Privileges: Activities conducted in the clinics must conform to the ACH mission statement. Physicians and affiliated health professionals practicing in ACH clinics shall have appropriate clinical privileges. ACH outpatient clinics are organized according to categories of care and will include, among others, a general pediatric clinic and subspecialty clinics. Each clinic will have a clinic medical director who is either the chief of the appropriate service or who may be appointed by the chief of service.

4.5.4 Patient Care in ACH Clinics: The clinic medical director shall follow general guidelines consistent with the mission of the hospital to provide care to all pediatric patients while striving for the highest quality of care and offering the opportunity for professional education. Each clinic will endeavor to meet standards of care as per developed policies.

4.5.5 Scheduling: The process of scheduling patients for a specific clinic is the responsibility of the medical and administrative directors. Patients scheduled per unit of time may vary from clinic to clinic. The number should be sufficient to maximize the available space and allow for patient flow with minimal waiting time. Though the time allotted per clinic visit per patient will vary, the physician responsible for the patient shall make every effort to efficiently utilize the time.

4.5.6 Clinic Charting: All records of patients seen on an outpatient basis shall be incorporated into the patient's official hospital medical record. The physician shall document the patient's chief complaint and medical history, the findings of the physical examination, evidence of previous laboratory evaluations, an assessment of the diagnosis or medical impression, and a plan for the future. This plan should include identifying appropriate tests or laboratory evaluations to be ordered, therapies to be administered and specific recommendations to the patient and his or her family. The physician's documentation should contain evidence of communication with the referring physician or health care agencies and pertinent patient education and/or discharge instructions. The documents should be appropriately signed. Dictated letters to referring physicians may serve as the official clinic visit documentation so long as all the basic requirements for documentation are met within the letter.

4.5.7 Quality Improvement: Quality improvement issues related to clinic activities will be addressed by the Outpatient Care Committee. These issues may relate to questions of patient care, physician compliance with expected standards of practice in ACH clinics, pertinent peer review activities and any other questions related to the quality of medical services provided in any ACH sponsored clinic facility. Clinic physicians and support personnel will be encouraged to take part in specific quality improvement activities. The results of such activities will be reviewed by the Outpatient Care Committee which will be responsible for providing appropriate responses and reporting these efforts to the Patient Care Committee.

4.5.8 Non-invasive Procedures Performed on an Outpatient Basis Outside of OR

4.5.8.1 Patients referred for non-invasive procedures (e.g. MRI, CT) are not required to have a medical history and physical examination completed at ACH prior to the procedure.

4.5.8.2 Patients who require sedation shall have an appropriate anesthesia history and physical examination consistent with the hospital policy for use of sedation outside the O.R (Hospital Policy I-17 Use of Sedation or Analgesia During Procedures)

4.5.8.3 Time Out Immediately Prior to the Start of Procedure: When applicable and immediately prior to the start of a procedure, the team will perform a time out to assure the right patient, right procedure, and right site. Administrative Policy A19: Verification of Patient and Procedure.

4.6 SPECIAL CARE UNITS

4.6.1 Special care units such as PICU, NICU, CVICU, the Burn Unit and Renal Dialysis Unit, will have specific regulations and procedure manuals. The Medical Director of each special care unit will draft such regulations and procedures for review by the Intensive Care Committee and approval of the Medical Staff Executive Committee.

4.7 PSYCHIATRIC SERVICE: The Arkansas Children's Hospital Psychiatry Service consists of the following services:

4.7.1 Consultation for inpatients and emergency patients.

4.7.2 Outpatient evaluation and treatment consisting of psychiatric, psychological and psychosocial evaluation, medication management, individual, group and family psychotherapy, case management, school consultation, parent-child interactive therapy and dyadic therapy.

4.7.3 Liaison with State Hospital Adolescent Center, Youth Home residential treatment facilities and other community Mental Health Agencies/services as established by ACH psychiatric staff members.

5. PERFORMANCE IMPROVEMENT

5.1 PARTICIPATION: All staff agree to participate in performance/quality improvement and patient safety activities as stated within the Performance Improvement Program (Admin Policy O1), Patient Safety Program (Administrative Policy O8), and Medical Staff Bylaws and Rules and Regulations.

5.2 EVALUATION OF CARE

5.2.1 Medical care provided by members of the medical staff will be evaluated both through care delivered directly by the staff member and care delivered by housestaff assigned to the member of the medical staff for care of the patient.

5.2.3 Policies and procedures for peer review are approved by the Medical Staff Executive Committee.

ARKANSAS CHILDREN'S HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS

APPROVED: Arkansas Children's Hospital Medical Staff Executive Committee
April 12, 2005

J. Michael Vollers, M.D. Chief of Staff

APPROVED: Arkansas Children's Hospital Medical Staff
April 19, 2005

J. Michael Vollers, M.D. Chief of Staff

APPROVED: Arkansas Children's Hospital Board of Directors
April 27, 2005

Harry C. Erwin, III Chairman

REVISIONS

Revisions to **3.1.1 History and Physical and 4.1 Preoperative assessment and documentation** are made to reflect current practice and recommendations from JCAHO Survey. In summary, the changes are:

1. To add “plan of care” or “plan of perioperative” during the H&P.
2. If an H&P is performed within 30 days prior to admission or before surgery, a copy of the H&P may be placed in the medical record. The revision clarifies that a written update must be done within 24 hours after admission or immediately prior to the surgery.
3. Adds that an advanced practice nurse with privileges may document the H&P and that the attending will countersign.
4. Adds that, when an anesthesiologist performs the comprehensive pre-procedure H&P, the surgeon will document an abbreviated H&P relative to the procedure.
5. Adds that when anesthesia/sedation is used for certain procedures (i.e. CT, MRI), the physician administering the anesthesia/sedation may perform the H&P.

Approved by Surgical Affairs Committee 4/19/2006

Approved by Medical Staff Executive Committee 5/9/2006

Approved by the Board of Trustees 5/24/2006

Reasons for Addition: Many of the regulations and standards addressed by the Center for Medicare and Medicaid Services (CMS), Arkansas Department of Health and Human Services, and Joint Commission are addressed in administrative and departmental policies. While administrative policies are available to all with access to the vault, departmental policies are often available only at the department level. The addition proposed is to address organizational level practice applicable to medical staff and hospital staff.

Proposed Addition:

4.2 RULES REGARDING ANESTHESIA SERVICES

4.2.1 General Consideration: The standards for anesthesia care apply when patients in any setting receive, for any purpose, by any route, the following:

- General anesthesia or other major regional anesthesia, such as spinal or epidural anesthesia (Refer to Anesthesia Department Policies)

or

- Moderate or deep sedation (with or without analgesia) that, in the manner used, may be reasonably expected to result in the loss of protective reflexes. (Refer to Administrative Policy I17: Use of Sedation or Analgesia During Procedures)

4.2.2 If a patient is to receive general anesthesia, other major regional anesthesia, or moderate or deep sedation, a practitioner with privileges to administer anesthesia or sedation shall perform a pre-anesthetic/sedation evaluation prior to the diagnostic or therapeutic procedure. For all instances of general anesthesia or moderate or deep sedation, the patient must be reassessed immediately prior to the administration of anesthesia or sedation.

4.2.3 With respect to inpatients following general, regional anesthesia, or moderate sedation, a postanesthesia/sedation evaluation must be completed and documented by an individual with privileges to administer anesthesia or sedation. The post anesthesia/sedation evaluation will be done after the patient finishes the recovery period and within 48 hours following the diagnostic or therapeutic procedure.

4.2.4 With respect to outpatients, a postanesthesia/sedation evaluation for proper anesthesia/sedation recovery is performed prior to discharge from the care setting and in accordance with policies and procedures approved by the medical staff.

Approved by MSEC: March 6, 2007

Approved by Board: March 28, 2007

Reason for Proposed Addition: In the 2005 revisions to the Rules and Regulations, a change was made to include outpatient clinics in medical screening (previously only applied to ED) and the statement was moved to a general section (versus ED only). At that time, the statement clarifying who may conduct medical screenings was omitted. Legal Affairs/Risk Management has recommended that the proposed addition be included in the EMERGENCY SERVICE section of the Rules and Regulations to meet EMTALA and Health Department regulations.

Arkansas Department of Health

F. Staffing.

1. Each patient presenting to the emergency department shall have a medical screening examination by a qualified medical personnel. The examination shall be completely documented. If a physician is not present, the qualified medical personnel shall contact the physician requested by the patient or the physician on call to discuss the assessment findings and determine the patient's condition.

2. Arrangements shall be provided, such as a duty or on-call roster, to ensure a physician is available for all emergency patients as determined by the screening examination.

Arrangements shall be made for obtaining specialized medical services.

Delete the following:

~~1.1.3.3 Any individual who comes to the outpatient clinic or the emergency department and requests examination or treatment will be provided an appropriate medical screening within the capability of the hospital's facilities to determine whether or not an emergency medical condition exists. If an emergency medical condition exists, the hospital will provide within the capabilities of the staff and facilities such further medical treatment or examination as is required to stabilize the medical condition. Upon stabilization, the patient will be transferred to an appropriate facility. If it is not within the capabilities of the hospital staff and facilities to stabilize the medical condition of the patient, the hospital shall make an appropriate transfer in compliance with the Emergency Medical Treatment and Active Labor Act of COBRA.~~

PROPOSED ADDITION:

4.2 EMERGENCY SERVICE

4.2.3 Medical Screening Examinations

Determination of whether an individual who comes to the Emergency Department has an emergency medical condition shall be made by a physician. Medical screening examinations in remote clinical sites not routinely staffed by physicians will be conducted by a Registered Nurse, an Advanced Practice Nurse or a Registered Nurse Practitioner. If an emergency medical condition exists, the hospital will provide within the capabilities of the staff and facilities such further medical treatment or examination as is required to stabilize the patients. If it is not within the capabilities of the hospital staff and facilities to stabilize the emergency medical condition of the patient, the patient will be admitted or transferred to an appropriate facility in compliance with Emergency Medical Treatment and Active Labor Act of COBRA.