

**MEDICAL STAFF BYLAWS, POLICIES, AND  
RULES AND REGULATIONS  
OF  
ARKANSAS CHILDREN'S HOSPITAL**

**MEDICAL STAFF  
RULES AND REGULATIONS  
OF  
ARKANSAS CHILDREN'S  
HOSPITAL**

*Revisions Adopted by the Medical Executive Committee January 21, 2020*

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## ARTICLE I

### DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Credentials Policy:

- (a) “Admitting Physician” means the physician who orders the admission of a given patient to the Hospital.
- (b) “Ambulatory Care” means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.
- (c) “Ambulatory Care Location” means any department in the Hospital or provider-based site or facility where ambulatory care is provided.
- (d) “Attending Physician” means the patient’s primary treating physician or his or her qualified designee(s) (e.g., the attending physician’s covering physician or an appropriately privileged Advance Practice Professional), who shall be responsible for directing and supervising the patient’s overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient’s status to the patient, the referring practitioner, if any, and the patient’s family.
- (e) “Practitioner” means, unless otherwise expressly limited, any appropriately credentialed physician, dentist, oral surgeon, or Advance Practice Professional, acting within his or her clinical privileges or scope of practice.
- (f) “Responsible Practitioner” means any practitioner who is actively involved in the care of a patient at any point during the patient’s treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND  
CARE, TREATMENT AND SERVICES

2.A. ADMISSIONS

- (1) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges. All Medical Staff members will be governed by the official admitting policy of the Hospital.
- (2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than 24 hours after admission.
- (3) Patients will be admitted based on the following order of priority during periods of limited bed space:
  - (a) **Emergency** – as designated by the attending physician;
  - (b) **Urgent** – as designated by the admitting physician;
  - (c) **Prescheduled Admissions** – includes patients already scheduled for surgery or other special procedures; and
  - (d) **Routine Elective Admissions** – includes elective, unscheduled admissions involving all services.
- (4) Areas of restricted bed utilization and preferred assignment of patients shall be defined within administrative and departmental policies approved jointly by administration and the Medical Staff.

- (5) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.
- (a) **Restraints** – When a patient needs protection to avoid injury to self and/or others, restraints may be used in accordance with Hospital policy in order to immobilize or restrict activity. *See Restraint/Seclusion Policy.*
- (b) **Suicide Prevention** – In the event a patient is judged to be a suicide risk, the medical and nursing staff and Hospital administration will take precautions for the protection of the patient in accordance with Hospital policy. *See Suicide Precautions and Guidelines for Evaluation of Patients with Identified Emotional, Psychiatric, or Substance Abuse Problems.*
- (c) **Infectious Disease** – Patients with infectious diseases will be assigned rooms and isolated according to Hospital policy. *See Standard and Transmission Based (Isolation) Precautions (System-Wide) Policy.*
- (d) **Allergies** – All patients require allergy documentation on admission. No medication order will be entered without first documenting the patient’s allergy status.
- (6) *See Patient Admissions, Transfers, and Discharges (Physician) Policy.*

## 2.B. EMERGENCY ADMISSIONS

- (1) A patient to be admitted on an emergency basis who does not have a physician on the Hospital Medical Staff will be assigned to an attending physician on the applicable service.
- (2) If there is a disagreement over assignment of service or unit, the clinical attendings should communicate with each other and make a decision. If it cannot be resolved, the applicable Service Chief, the Chief of Staff (“COS”), or the Chief Medical Officer (“CMO”) will make the decision.

- (3) Admission to the Hospital requires a validly executed admission order and plan of care provided by the accepting unit attending physician.

## 2.C. TRANSFER PRIORITIES

Transfer priorities shall be as follows:

- (1) patients from any location to an intensive care bed;
- (2) Emergency Department patients, outpatients, and ambulatory surgery patients for emergency or urgent admission to a patient bed;
- (3) patients with transfer orders from an intensive care bed to other locations in order to free an intensive care bed for emergency admissions; and
- (4) patients from temporary placement in a non-specialty unit to the appropriate specialty unit for the patient.

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

## 2.D. RESPONSIBILITIES OF ATTENDING PHYSICIAN

- (1) The attending physician will be responsible while the patient is in the Hospital for the following:
  - (a) the medical care and treatment of any patient in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible) *See Acceptance of Adult Patient Policy, Transition to Adult Care Policy, and Interdisciplinary Coordination of Patient Care, Facilitation of Communication Policy;*

- (b) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;
  - (c) communicating with the patient's third-party payer, if needed;
  - (d) providing necessary patient instructions;
  - (e) responding to inquiries from Case Management professionals regarding the plan of care in order to justify the need for continued hospitalization;
  - (f) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate;
  - (g) performing all other duties described in these Rules and Regulations; and
  - (h) participating, as a part of the interdisciplinary team, in assessing and improving the education of patients and families. *See Patient/Caregiver Education Policy.*
- (2) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer. *See Patient Admissions, Transfers, and Discharge (Physician) Policy.*
- (3) The disposition of a patient in the PACU is the responsibility of the attending physician or his or her designee in whose name the procedure is scheduled. Care of the patient in the PACU is a dual responsibility of both the responsible anesthesiologist and surgeon as long as the patient is in the PACU.
- (4) After reasonable, good-faith efforts using institutional resources and dialogue, if there still is no agreement on the plan of care between the attending and patient,

parent/guardian, or surrogate (adult patient's decision-maker), the attending physician may ask for a meeting of an institutional interdisciplinary committee, which will determine medical appropriateness and any need for redirection of care. *See Redirection of Care Policy.*

- (5) Termination of the physician-patient relationship may need to occur under unusual circumstances when there are irreconcilable differences. To assure that there is no unilateral severance of the professional relationship between a health care provider and a patient without reasonable notice at a time when there is still a need for continuing health care (abandonment), the physician will refer to and adhere to Hospital policy. *See Terminating the Physician Patient Relationship Policy.*

## 2.E. AVAILABILITY AND ALTERNATE COVERAGE

- (1) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.
- (2) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:
  - (a) Routine Contacts from the Hospital – respond within 15 minutes, via phone;
  - (b) Request for In-Person Appearances (or via technology-enabled direct communication and evaluation, i.e., telemedicine) – attend to a patient within 60 minutes of being requested to do so (or more quickly as required for a particular specialty as recommended by the MEC and approved by the Board); and
  - (c) All Inpatient Admissions – the primary attending physician (or attending representing the service) must personally see the patient within 24 hours of admission and during each subsequent 24-hour period during hospitalization, and provide daily documentation of presence and oversight of care in the EMR.

- (3) All physicians (or their appropriately credentialed designee) will be expected to comply with the patient care guidelines regarding consultations outlined in Article 6 of these Medical Staff Rules and Regulations.
- (4) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.
- (5) If the attending physician is not available, the CMO, the COS, or the administrator on call will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

#### 2.F. CONTINUED HOSPITALIZATION

- (1) The attending physician will provide whatever information may be requested by the Case Management department with respect to the continued hospitalization of a patient, including:
  - (a) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);
  - (b) the estimated period of time the patient will need to remain in the Hospital; and
  - (c) plans for post-Hospital care.

This response will be provided to the Case Management department within 24 hours of the request. Failure to comply with this requirement will be reported to the MEC for appropriate action.



- (2) For admissions that are 20 days or more, or outlier cases, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:
  - (a) authentication of the admitting order;
  - (b) the reason for the continued hospitalization or the special or unusual services for a cost outlier case;
  - (c) the expected or actual length of stay of the patient; and
  - (d) the plans for post-Hospital care, when appropriate.
  
- (3) If the Case Management department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the CMO will be consulted.

Paragraph	Policy Reference
2.A(5)(a)	Restraint/Seclusion
2.A(5)(b)	Suicide Precautions
2.A(5)(b)	Guidelines for Evaluation of Patients with Identified Emotional, Psychiatric, or Substance Abuse Problems
2.A(5)(c)	Standard and Transitional Based (Isolation) Precautions (System-Wide)
2.A(6)	Patient Admissions, Transfers, and Discharges (Physicians)
2.D(1)(a)	Acceptance of Adult Patients
2.D(1)(a)	Transition to Adult Care
2.D(1)(a)	Interdisciplinary Coordination of Patient Care, Facilitation of Communication
2.D(1)(h)	Patient/Caregiver Education
2.D(2)	Patient Admissions, Transfers, and Discharges (Physicians)
2.D(4)	Redirection of Care
2.D(5)	Terminating the Physician Patient Relationship

## ARTICLE III

### MEDICAL RECORDS

#### 3.A. GENERAL

A medical record will be prepared for every individual evaluated and treated at the Hospital. Each practitioner who is involved in the care of a patient will be responsible for the timely, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides. *See Complete Medical Record Policy.*

#### 3.B. MEDICAL RECORD ENTRIES

##### 3.B.1. Entries:

Electronic entries will be entered through the electronic medical record (“EMR”) and/or Computerized Provider Order Entry (“CPOE”) in accordance with Hospital policy. Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including handwritten entries, must be timed, dated and signed.

##### 3.B.2. Authentication:

Authentication means to establish authorship by signature or identifiable initials and may include computer entry using a unique security log-on for electronic signatures and entries. Each practitioner who is authorized to make entries in the medical record will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy. Signature stamps are not an acceptable form of authentication for written orders and other medical record entries. Written signatures must include the responsible practitioner’s identification number. *See Electronic Signature Policy.*

### 3.B.3. Forms:

All forms and templates used for medical record documentation, both printed and electronic, shall be approved by the Clinical Forms Committee. *See Clinical Forms Policy.*

### 3.B.4. Abbreviations:

Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations shall be used in the medical record. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. In general, the use of abbreviations is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

### 3.B.5. Clarity, Legibility, and Completeness:

All entries in the medical record shall be clear, legible and complete so that other members of the health care team are able to understand the entry and the author's intentions.

### 3.B.6. Correction of Errors:

When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial entry. Any error made while entering an order in the EMR should be corrected by entering another order. Handwritten entries in the medical record will be corrected by making a single line through the original entry (noted with the word "error") and making any necessary addition/correction. Any addition/correction will be timed, dated and initialed by the author.

### 3.B.7. Copying and Pasting:

Copying and pasting from a prior note may not be utilized unless the pasted note is properly updated.

## 3.C. ACCESS TO RECORDS

### 3.C.1. Ownership of Record:

- (a) Medical records are the physical property of the Hospital and shall not be removed from the premises except by a subpoena, court order or in accordance with federal and state law and Hospital policy. Unauthorized removal of Hospital patient records from the Hospital facilities may be grounds for disciplinary action.
- (b) Only those practitioners with a legitimate reason to view a patient record may do so. Unauthorized viewing or removal of a patient record may be grounds for disciplinary action. The CMO shall be responsible for the enforcement of this rule. *See Use and Disclosure of Protected Health Information Policy.*

### 3.C.2. Authorized Individuals:

The following individuals are authorized to document in the medical record:

- (a) attending physicians, residents, interns and Advance Practice Professionals;
- (b) nursing providers, including registered nurses (“RNs”) and licensed practical nurses (“LPNs”);
- (c) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;
- (d) students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical students, nursing students) if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record; and
- (e) non-clinical and administrative staff, as appropriate, pursuant to their job description.

<b>Paragraph</b>	<b>Policy Reference</b>
3.A	Complete Medical Record
3.B.2	Electronic Signature
3.B.3	Clinical Form Policy
3.C.1(b)	Use and Disclosure of Protected Health Information

## ARTICLE IV

### CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

#### 4.A. CONTENT OF MEDICAL RECORD

##### 4.A.1. General Requirements:

All medical records for patients receiving evaluation or treatment in the Hospital or at an ambulatory care location will document the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
- (b) legal status of any patient receiving behavioral health services;
- (c) patient's language and communication needs, including preferred language for discussing health care;
- (d) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or Comfort Care orders; *See Comfort Care Policy and the Advanced Directives Policy*
- (e) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
- (f) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

- (g) admitting history (i.e., source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;
- (h) allergies to foods and medicines;
- (i) reason(s) for admission of care, treatment, and services;
- (j) diagnosis, diagnostic impression, or conditions;
- (k) goals of the treatment and treatment plan;
- (l) diagnostic and therapeutic orders, procedures, tests, and results;
- (m) progress notes made by authorized individuals;
- (n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
- (o) consultation reports;
- (p) operative procedure reports and/or notes;
- (q) any applicable anesthesia evaluations;
- (r) response to care, treatment, and services provided;
- (s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;



- (t) reassessments and plan of care revisions;
- (u) complications, Hospital acquired infections, and unfavorable reactions to medications and/or treatments;
- (v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and
- (w) medications dispensed or prescribed on discharge.

4.A.2. Progress Notes:

- (a) Progress notes will be written at least daily by the attending service for all patients who have been admitted to the Hospital and shall be dated, timed, and legible.
- (b) Progress notes shall be written by the attending physician or his or her covering practitioner, including an Advance Practice Professional as permitted by his or her clinical privileges or scope of practice. Whenever 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.

4.A.3. Consultative Reports:

Consultation reports will be completed in accordance with Article 6 of these Rules and Regulations.

4.A.4. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

#### 4.A.5. Operative Procedure Reports:

An operative procedure report must be dictated or written in accordance with Article 8 of these Rules and Regulations.

#### 4.A.6. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient's medical record on appropriate paper or electronic forms in accordance with Article 9.

#### 4.A.7. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

#### 4.A.8. Discharge Summary:

(a) For all patients hospitalized for over 48 hours, a comprehensive discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All such discharge summaries will include the following and must be completed within 72 hours of discharge:

- (1) reason for hospitalization;
- (2) significant findings;
- (3) procedures performed and care, treatment, and services provided;
- (4) condition and disposition at discharge;

- (5) information provided to the patient and family, as appropriate;
  - (6) provisions for follow-up care; and
  - (7) discharge medication reconciliation.
- (b) A discharge progress note may be used to document the discharge summary for stays of less than 48 hours, provided that the note contains the outcome of the hospitalization, disposition of the case, and provisions for follow-up care.
- (c) All parents/families will receive a Discharge Instructions Summary. The Discharge Instructions Summary may be used in place of a dictated discharge summary for patients who were admitted to observation status. Medications, care at home, follow-up appointments and plans shall be documented on the Discharge Instructions Summary.

#### 4.A.9. Emergency Care:

In addition to any of the applicable general requirements outlined in Section 4.A.1, the medical records of patients who have received emergency care will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
- (b) patient's language and communication needs, including preferred language for discussing health care;
- (c) time and means of arrival;
- (d) record of care prior to arrival;

- (e) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
- (f) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his arrival at the Emergency Department;
- (g) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;
- (h) treatment given, if any;
- (i) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;
- (j) if the patient left against medical advice; and
- (k) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

The emergency record shall be documented at the time of service, but no later than immediately following discharge/transfer of the patient from the Emergency Department.

#### 4.B. TIMELINESS OF DOCUMENTATION

- (1) Inpatient Charting Requirements. A summary assessment and plan must be documented in an inpatient medical record within 72 hours of admission and the medical record must be completed and signed within 14 days following the patient's discharge. It is the responsibility of any practitioner involved in the care of a patient to prepare and complete medical records in accordance with these time frames, as well as the other provisions of these Rules and Regulations and any other relevant policies of the Hospital.

- (2) Clinic Charting Requirements. All records of patients seen on an outpatient basis shall be incorporated into the patient's Hospital medical record. A summary assessment and plan must be documented in the medical record within 72 hours of the patient being seen. The final documentation, which must be completed and signed within 14 days, must include the patient's chief complaint and medical history, the findings of the physical examination, medication list, and 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 medications to be administered and specific recommendations to the patient and his or her family. Additionally, the documentation must include pertinent patient education and/or discharge instructions. The documents should be appropriately signed.
- (3) Monitoring. On the first day of each work week (Monday or Tuesday if Monday is a holiday), the HIM Department will run a report of all practitioners with incomplete records that have exceeded 7 days, and a reminder notification will be sent to each provider. If each record has not been completed by the following Monday and at that point is at > 14 days, it will be considered delinquent and the provider will be thus informed. At that point, the provider will have 7 additional days to complete the record to avoid an associated fine. HIM staff will verify the validity of each deficiency listed. HIM staff will attempt to contact each practitioner on the report by phone, pager, or e-mail as indicated.
- (4) Notification. The HIM Department will notify the service chiefs each week of all practitioners within their specific service who have delinquent charts (>14 days). Practitioners will be individually notified as a reminder by e-mail with records that have exceeded the 7 day mark, and by email and phone of delinquent records that have exceeded the 14 day limit.
- (5) Enforcement. Practitioners must review their chart deficiency list upon receipt and report any discrepancies to the HIM staff.
- (a) **Fines.** On the Monday whereby the record has not been completed at the > 21 day limit, a fine of \$100 per encounter will be levied and the practitioner and appropriate service chief will be notified. The fine notification will be sent to the Department Chair.
- (b) **Automatic Relinquishment.** In the event a practitioner is fined three months within the same two-year period, the HIM Department will notify the

practitioner that his or her clinical privileges have been relinquished. The COS, emergency department and nursing administration will also be notified. The relinquishment will take effect immediately and the practitioner will be responsible for cancelling any cases scheduled at the Hospital and for transferring the care of any patients in the Hospital to a practitioner who has appropriate clinical privileges. The relinquishment will remain in effect until the delinquent records are completed or until his or her appointment and clinical privileges are resigned in accordance with (C) below.

(c) **Automatic Resignation.** A practitioner who automatically relinquishes his or her privileges will be given 30 days to complete the delinquent records. Failure to do so indicates an inability or unwillingness to fulfill the standards in these Rules and Regulations. Accordingly, that practitioner will automatically resign his or her Medical Staff appointment and all clinical privileges.

(6) Rejoining the Medical Staff After Resignation. Any practitioner who automatically resigns his or her appointment and clinical privileges as a result of medical record delinquencies may subsequently apply to the Medical Staff as an initial applicant, provided that all delinquent medical records have been completed. The individual may not be granted any temporary privileges while the application is being processed until all records are completed.

(7) Closing of Medical Records. A medical record will not be considered closed until it is completed by the responsible practitioner or it is ordered administratively closed by the HIM Department. Except in rare circumstances, and only when approved by the HIM Department, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to close that record.

(8) Former Members. When a physician is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the physician’s credentials file and divulged in response to any future credentialing inquiry concerning the physician.

Paragraph	Policy Reference
4.A.1(d)	Comfort Care
4.A.1(d)	Advance Directives

## ARTICLE V

### MEDICAL ORDERS

#### 5.A. GENERAL

- (1) Orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE, except when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR.
  
- (2) All orders (including verbal/telephone orders) must be:
  - (a) dated and timed when documented or initiated;
  
  - (b) authenticated (manually or electronically) by the ordering practitioner, with the exception of a verbal order which may be countersigned by another practitioner who is responsible for the care of a patient; and
  
  - (c) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.
  
- (3) All previous orders are automatically cancelled when a patient goes to surgery.
  
- (4) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.

## 5.B. ORDERS FOR TESTS AND THERAPIES

- (1) Orders for tests and therapies will be accepted only from:
  - (a) members of the Medical Staff;
  - (b) Advance Practice Professionals to the extent permitted by their licenses and clinical privileges; and
  - (c) inpatient residents and subspecialty residents.
- (2) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.
- (3) Outpatient orders for services such as, but not limited to, physical therapy, rehabilitation, or laboratory may also be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy. *See Practitioners Verification for Outpatient Testing Policy.*

## 5.C. ORDERS FOR MEDICATIONS

- (1) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations. When medication is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered.
- (2) The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.



- (3) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.
- (4) A medication reconciliation should be completed in accordance with the Medication Reconciliation Policy.

The individual performing the reconciliation will use the EMR in each of these instances when performing the above. Any medication discrepancies are to be resolved by the provider.

- (5) Advance practice providers may be authorized to issue medication orders as specifically delineated by their licensing board within their clinical privileges.

#### 5.D. VERBAL AND TELEPHONE ORDERS

- (1) A verbal order (physician is physically present when order is given) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care. *See Verbal and Telephone Orders Policy.*
- (2) For orders given over the telephone (i.e., physician is not physically present when the order is given and only available by phone), the ordering practitioner must identify himself or herself and his or her credentials.
- (3) All verbal and telephone orders will include the date and time of entry into the medical record and identify the names and titles of the individuals who gave, received, and implemented the order. Verbal orders will then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.
- (4) The ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, will countersign the verbal order (i) before the ordering practitioner leaves the patient care area for urgent or emergent verbal orders given in person, and (ii) within 72 hours after the order was given for telephone orders at the Hospital.

- (5) For verbal and telephone orders, the complete order will be verified by having the person receiving the information record and “read-back” the complete order as the order is entered. This will serve to eliminate errors related to sound-alike drugs and other common discrepancies in transmission and acceptance of verbal and telephone orders.
- (6) Verbal orders may be received and recorded by licensed professionals as authorized by law or their scope of practice.

#### 5.E. STANDING ORDERS, ORDER SETS, AND PROTOCOLS

- (1) The MEC and the Hospital’s nursing and pharmacy departments must review and approve any standing orders, order sets, and protocols (collectively, “standing orders”) that permit treatment to be initiated by an individual (for example, a nurse) without a prior specific order from the attending physician. All standing orders will identify well-defined clinical scenarios for when the order is to be used. *See Orders, Protocols, and Pathways Policy.*
- (2) The MEC will confirm that all approved standing orders are consistent with nationally recognized and evidence-based guidelines. The MEC will also ensure that such standing orders are reviewed periodically.
- (3) If the use of a standing order has been approved by the MEC, treatment may be initiated for a patient pursuant to the standing order: (1) by a nurse or other authorized individual acting within his or her scope of practice who activates the order; or (2) when a nurse enters documentation into the medical record that triggers the standing order.
- (4) When used, standing orders must be dated, timed, and authenticated promptly in the patient’s medical record by the individual who activates the order or by another responsible practitioner.
- (5) The attending physician must authenticate the initiation of each standing order within 14 days, with the exception of those for influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications.

#### 5.F. SELF-ADMINISTRATION OF MEDICATIONS

The self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will be permitted in accordance with the Authorization to Administer Medications Policy and the Medications from Home Policy.

#### 5.G. STOP ORDERS

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders and automatically discontinued as follows:

- (1) on all radiology orders after 24 hours; and
- (2) for medications, see Medication Stop Orders Policy.

#### 5.H. COMFORT CARE ORDERS RESUSCITATION EFFORTS

- (1) When standard curative treatments and therapies are determined to be medically futile, the medical team and Hospital staff will provide compassionate care (Comfort Care), which includes medical, social, and psychological support to patients and families through the end-of-life process. *See Comfort Care Policy.*
- (2) A decision to forgo any or all resuscitation measures must be clearly documented in the patient's medical record and conform to the Advanced Directive Policy, and applicable orders delineated in the order form. *See Advanced Directive Policy.*

#### 5.I. DISCHARGE ORDER

Patients shall be discharged only upon the order of the attending physician or another physician acting as his or her designee in accordance with Article XII.

Paragraph	Policy Reference
5.B(3)	Practitioners Verification for Outpatient Testing
5.C(4)	Medication Reconciliation
5.D(1)	Verbal and Telephone Orders
5.E(1)	Orders, Protocols, and Pathways
5.F	Authorization to Administer Medications
5.F	Medications from Home
5.H(1)	Comfort Care
5.H(2)	Advanced Directives
5.G	Medication Stop Orders

## ARTICLE VI

### CONSULTATIONS

#### 6.A. REQUESTING CONSULTATIONS

- (1) The attending physician shall be responsible for approving the request for a consultation when indicated and ensuring the team contacts a qualified consultant.
- (2) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician or designee will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for emergent consults, the attending physician or fellow must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.
- (3) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed under the Professional Practice Evaluation Policy or other applicable policy.
- (4) Where a consultation is required for a patient in accordance with these Rules and Regulations or is otherwise determined to be in patient's best interest, the CMO, the COS, or the appropriate Service Chief shall have the right to call in a consultant.

#### 6.B. RESPONDING TO CONSULTATION REQUESTS

- (1) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. The individual, or a member of his or her coverage group, will respond to the request. In either case, the individual responding to a request ("consulting physician") is expected to respond in accordance with the patient care guidelines as per the Inpatient Medical Services Consultation Policy.
- (2) The consulting physician may ask a resident, fellow, or qualified Advance Practice Professional with appropriate clinical privileges to see the patient, gather data, order

tests, and generate documentation. However, an evaluation by such an individual will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the Advance Practice Professional is sufficient.

- (3) Once the consulting physician is involved in the care of the patient, the attending physician and consulting physician (or their designees) are expected to communicate as indicated based on the patient's condition until such time as the consultant has signed off on the case or the patient is discharged.
  
- (4) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the CMO, the COS, or the appropriate Service Chief. Any confirmed failure to respond to a consultation in a timely and appropriate manner may be reviewed under the Professional Practice Evaluation Policy or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation:
  - (a) the physician has a valid justification for his or her unavailability (e.g., out of town);
  
  - (b) the patient has previously been discharged from the practice of the physician;
  
  - (c) the physician has previously been dismissed by the patient;
  
  - (d) the patient indicates a preference for another consultant; or
  
  - (e) other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (a)-(e)), the requesting physician should find an alternate consultant. If the attending is unable to do so, then the CMO, COS, or appropriate Service Chief can appoint an alternate consultant.

- (5) Any other health care provider with concerns regarding the care of a patient, or who believes that additional consultation is required, should bring this concern to the attention of his or her immediate supervisor, who is responsible for evaluating the situation and arranging for appropriate follow-up and reporting.

#### 6.C. REQUIRED AND RECOMMENDED CONSULTATIONS

- (1) Except in emergency cases, consultations are required in the following situations:
  - (a) attempted suicide by a patient (consultation by Social Work); and
  - (b) inpatients with suspicion of child maltreatment or neglect (consultation by the Team for Children at Risk).
- (2) Consultations are recommended when requested by the patient or his or her family and it is appropriate to the patient's condition.
- (3) Additional requirements for consultation may be established by the Hospital as required.

#### 6.D. MENTAL HEALTH CONSULTATIONS

- (1) Consultation for inpatients and patients in the Emergency Department requiring psychiatric evaluation and triage is provided 24 hours per day, seven days per week. Emergency consults are responded to within 60 minutes, and routine consults will be seen within 24 hours.
- (2) Comprehensive outpatient evaluation and treatment for children between the ages of two and 14 are available. Outpatient treatment for adolescents over the age of 14 is provided at the Walker Family Clinic in the UAMS Psychiatric Research Institute. Psychiatry staff at the Hospital will help facilitate evaluation of patients age 14 years and older.

#### 6.E. CONSULTATION REPORTS

- (1) Consultation reports will be completed in accordance with the time frames identified in the Inpatient Medical Services Consultation Policy as an EMR-generated note or, when the EMR is unavailable, through a dictated or legible written note. The note will contain opinions and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient’s medical record. A statement such as “I concur” will not constitute an acceptable consultation report. The consultation report will be made a part of the patient’s medical record. *See Inpatient Medical Services Consultation Policy.*
  
- (2) When non-emergency operative procedures are involved, the consultant’s report will be recorded in the patient’s medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant finding and reasons, and the authentication of the consultant.

**6.F. SURGICAL CONSULTATIONS**

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, will be entered into the patient’s medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed unless the attending physician states in writing that an emergency situation exists.

Paragraph	Policy Reference
6.B(1) and 6.E(1)	Inpatient Medical Services Consultations



## ARTICLE VII

### INFORMED CONSENT

#### 7.A. GENERAL

- (1) It is the attending physician's responsibility to obtain the informed consent. The medical record shall contain evidence of informed consent being obtained or the reason why it is not obtainable. *See Patient Consent to Treatment Policy.*
- (2) The attending physician should collaborate with patients and parents in making decisions regarding care. Patients should participate in decision-making commensurate with their development and should assent to care whenever reasonable. *Refer to the American Academy of Pediatrics Bioethics Committee Policy Statement – Informed Consent, Parental Permission, and Assent in Pediatric Practice.*
- (3) If immediate treatment is required for an emergency (to preserve life or limb or prevent serious impairment of health), and it is impossible to obtain informed consent, the attending physician must declare medical necessity and may proceed with the required procedures. In accordance with Hospital policy on patient consent to treatment, the attending physician must document the circumstances in the medical record as soon as possible. It is not considered an emergency if a delay will not materially increase the hazards, even though it may be clear that the medical treatment in question will be needed.

#### 7.B. INFORMED CONSENT FOR SURGICAL SERVICES

- (1) Standard informed consent documents for surgery and anesthesia must be properly completed, dated, and timed by a practitioner authorized to perform the procedure. Properly executed informed consents are valid for up to 30 days prior to the surgical procedure. Hospital or procedural staff will confirm the consents on the day of the procedure and document confirmation in the patient's medical record. Consent by telephone may be obtained by the physician who converses with the parent(s) or guardian(s). Witnesses for completion of the informed consent permit or witnessing of

consents by telephone must be in accordance with the Patient Consent to Treatment Policy.

- (2) Should a second operation be required during the patient’s stay in the Hospital, a second consent specific to that procedure will be obtained.
  
- (3) If two or more specific procedures are to be carried out under the same anesthetic and this is known in advance, all procedures must be described in the consent obtained. Certain recurring procedures may fall under the Hospital Durable Consent as outlined in the Patient Consent for Treatment policy.

<b>Paragraph</b>	<b>Policy</b>
7.A(1)	Patient Consent for Treatment

## ARTICLE VIII

### SURGICAL SERVICES

#### 8.A. ORGANIZATION AND STAFFING

- (1) A daily operating room schedule will be planned and executed in order to make maximum, efficient use of the operating room and the anesthesia service, in accordance with Hospital policies and procedures, as approved by the Perioperative Services Council.
- (2) Every effort should be made to adhere to the scheduled start time of any surgical procedure. Flagrant or habitual violation will be reported to the Perioperative Services Council.
- (3) If a surgeon deems a case as emergent (i.e., needing to take priority over another case), he or she will make this declaration to the nurse in charge. The nurse in charge, along with the anesthesiologist in charge, will determine which case will be postponed and alert the requesting surgeon. It is the requesting surgeon's responsibility to contact the postponed surgeon and discuss his or her need. If the two surgeons cannot come to an agreement on the urgency/case order, the chief of surgery will be contacted to make a final decision on case order. *See OR Scheduling Policy.*

#### 8.B. PRE-PROCEDURAL PROCEDURES

- (1) Provisional Diagnosis.
  - (a) Except in emergencies, the preoperative diagnosis of the patient and appropriate laboratory tests must be recorded in the patient's medical record prior to beginning any surgical or invasive procedure or the procedure shall be canceled.

- (b) In an emergency, the practitioner shall make a comprehensive note regarding the patient's clinical status and the nature of the emergency procedure, anesthesia used, and start of the operation.

(2) History & Physicals.

Refer to Medical Staff Bylaws, Appendix B.

(3) Diagnostic Procedures.

Any preoperative laboratory or x-ray examinations should be completed and documented using two identifiers that can be used to verify that the information belongs to the patient.

(4) Informed Consent.

Refer to Article 7 of these Rules and Regulations.

- (5) Time Out. In accordance with Hospital policy, a World Health Organization ("WHO") checklist will be performed. Immediately prior to the start of a procedure, the procedural team will perform a time out in accordance with the Hospital policy on Verification of Patient, Procedure, and Operative Site (Time Out) and Patient Identification Policy.

### 8.C. POST-PROCEDURAL PROCEDURES

- (1) An operative procedure report must be dictated or written immediately after an operative procedure and entered into the record. The operative procedure report shall include:
- (a) the patient's name and Hospital identification number;

- (b) pre- and post-operative diagnoses;
  - (c) date and time of the procedure;
  - (d) the name of the attending physician and assistant surgeon(s) responsible for the patient's operation;
  - (e) procedure(s) performed and description of the procedure(s);
  - (f) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
  - (g) findings, where appropriate, given the nature of the procedure;
  - (h) estimated blood loss;
  - (i) any unusual events or any complications, including blood transfusion reactions and the management of those events;
  - (j) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
  - (k) specimen(s) removed, if any;
  - (l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and
  - (m) the signature of the attending physician.
- (2) If a full operative procedure report cannot be entered into the record immediately after the operation or procedure, a progress note must be entered by a physician (attending surgeon or resident only) in the medical record immediately after the procedure. In

such situations, the full operative procedure report must be entered or dictated within 24 hours. The progress note will include:

- (a) the names of the physician(s) responsible for the patient’s care and physician assistants;
- (b) the name and description of the procedure(s) performed;
- (c) findings, where appropriate, given the nature of the procedure;
- (d) estimated blood loss, when applicable or significant;
- (e) specimens removed; and
- (f) post-operative diagnosis.

**8.D. PATHOLOGY PROCEDURES**

All appropriate specimens will be sent to the Hospital 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 Perioperative Services Council and the Chief of Pathology and approved by the MEC. *See Specimens Exempt From the Requirement of Pathologic Examination or Specimens Submitted for Gross Pathologic Exam Policy.*

Paragraph	Policy Reference
8.A(3)	OR Scheduling Policy
8.B(5)	Verification of Patient, Procedure, and Operative Site (Time Out)
8.B(5)	Patient Identification
8.D	Specimens Exempt From the Requirement of Pathologic Examination

	or Specimens Submitted for Gross Pathologic Exam
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## ARTICLE IX

### ANESTHESIA SERVICES

#### 9.A. GENERAL

- (1) Anesthesia may only be administered by the following qualified practitioners:
  - (a) an anesthesiologist;
  - (b) a Medical Staff member who has appropriate licensure and who has been granted clinical privileges to administer anesthesia in a specific patient care area or for a specific procedure (e.g., Emergency Department and GI procedures); or
  - (c) an Advanced Practice Professional (“APP”), physician trainee, or other authorized provider who is supervised by an anesthesiologist who is immediately available. An anesthesiologist is considered “immediately available” when needed by an APP under the anesthesiologist’s supervision only if he/she is physically located within the same area as the APP, physician trainee, or other authorized provider (e.g., in the same operative suite, labor and delivery unit, or procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).
- (2) “Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal or moderate sedation, or analgesia via epidurals/spinals for labor and delivery.
- (3) Because it is not always possible to predict how an individual patient will respond to minimal or moderate sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.



## 9.B. PRE-ANESTHESIA PROCEDURES

- (1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia.
  
- (2) The following elements of the pre-anesthesia evaluation must be performed within 48 hours immediately prior to an inpatient or outpatient surgery or procedure requiring anesthesia services:
  - (a) a review of the medical history, including anesthesia, drug and allergy history; and
  
  - (b) an interview, if possible, pre-procedural education, and examination of the patient.
  
- (3) The following additional elements of the pre-anesthesia evaluation may be performed up to 30 days prior to an inpatient or outpatient surgery or procedure requiring anesthesia services, but must be reviewed and updated as necessary within 48 hours of the surgery or procedure:
  - (a) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
  
  - (b) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway as identified through an airway examination, any ongoing infections, limited intravascular access);
  
  - (c) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and
  
  - (d) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

Per the Centers for Medicare & Medicaid Services Conditions of Participation, under no circumstances may these elements be performed more than 30 days prior to surgery or a procedure requiring anesthesia services.

- (4) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

#### 9.C. MONITORING DURING PROCEDURE

- (1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor the patient per current ASA standards.
- (2) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including at least the following:
  - (a) the name and Hospital identification number of the patient;
  - (b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;
  - (c) the name, dosage, route, time, and duration of all anesthetic agents;
  - (d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;
  - (e) the name and amounts of IV fluids, including blood or blood products, if applicable;
  - (f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

- (g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

#### 9.D. POST-ANESTHESIA EVALUATIONS

- (1) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.
  
- (2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).
  
- (3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
  - (a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
  
  - (b) cardiovascular function, including pulse rate and blood pressure;
  
  - (c) mental status;
  
  - (d) temperature;
  
  - (e) pain;

- (f) nausea and vomiting; and
  - (g) post-operative hydrations.
- 
- (4) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists (“ASA”), using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.
  - (5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
  - (6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

#### 9.E. MINIMAL AND MODERATE SEDATION

All patients receiving minimal or moderate sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner in accordance with applicable Hospital policies. However, such procedures are not subject to the requirements regarding pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations described in this Article. *See Moderate/Deep Procedural Sedation Policy.*

#### 9.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and

- evaluating the quality and appropriateness of anesthesia patient care.

<b>Paragraph</b>	<b>Policy Reference</b>
9.E	Moderate/Deep Procedural Sedation

## ARTICLE X

### PHARMACY

#### 10.A. GENERAL RULES

- (1) Orders for drugs and biologicals are addressed in the Medical Orders, Article 5. The Hospital policy on Inpatient Medical Orders is available in the Hospital's electronic policy system on the Team ACH homepage.
- (2) Adverse drug reactions ("ADR") are reported as specified in the Adverse Drug Reaction Reporting Policy. Medication errors will be immediately documented according to the Patient Occurrence Reporting System's policy in a Safety Tracker and reported to the attending physician and, if appropriate, to the Hospital's quality assessment and performance improvement program.
- (3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner, unless otherwise specified by the ordering physician (e.g., when the ordering physician specifies "brand name necessary"). *See Generic and Therapeutic Equivalent Substitution Policy.*
- (4) All drugs and medications administered to patients shall be those listed in the Hospital formulary unless an exception is granted in accordance with the Pharmacy & Therapeutics Committee Formulary policy. The formulary is available on the Team ACH homepage under LexiComp (ACH Formulary). Investigational drugs will be ordered by the authorized prescribers per the Investigational Drug, Investigational Studies Policy after all required approvals are obtained (Institutional Review Board, etc.).
- (5) Information on medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, Advance Practice Professionals and other Hospital personnel on the Team ACH homepage under LexiComp (ACH Formulary) and in other electronic references.

10.B. STORAGE AND ACCESS

- (1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.
  - (a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff. *See Medication Security and Storage Policy.*
  - (b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area or in an automated dispensing machine. *See Controlled Substances General and Automated Dispensing Machine Policies.*
  - (c) Only authorized personnel may have access to locked or secure areas or automated dispensing machines.
  
- (2) Abuses and losses of controlled substances will be reported as stated in the Controlled Substances General (System-Wide) Policy.

Paragraph	Policy Reference
10.A(1)	Inpatient Medication Orders
10.A(2)	Adverse Drug Reaction Reporting
10.A(2)	Patient Occurrence Reporting System
10.A(3)	Generic and Therapeutic Equivalent Substitution
10.A(4)	Formulary
10.A(4)	Investigational Drug
10(B)(1)(a)	Medication Security and Storage
10.B(1)(b)	Controlled Substances General

10.B(1)(b)	Automated Dispensing Machine
10.B(2)	Controlled Substances General (System-Wide)



## ARTICLE XI

### EMERGENCY SERVICES

#### 11.A. GENERAL

- (1) A Medical Staff physician will be on duty in the Emergency Department 24 hours per day. Additional Medical Staff coverage and initial consultation may be provided by house officers and appropriately credentialed Advance Practice Professionals under the supervision of a member of the Medical Staff.
- (2) When a patient's primary care physician is a community physician who is a member of the Medical Staff, and he or she desires to be contacted, this physician should be notified at the earliest appropriate time that his or her patient has presented to the Emergency Department. If this physician chooses not to come to treat his or her patient, a report of the Emergency Department visit will be provided to him or her.

#### 11.B. EMERGENCY LOG

The name of every patient seeking emergency care will be recorded on the Emergency Log with the patient's disposition indicated. Following a medical screening examination, patients with no emergency medical condition may be sent to a more appropriate area to receive any necessary care.

#### 11.C. MEDICAL SCREENING EXAMINATIONS

- (1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel ("QMP") who can perform medical screening examinations in the Emergency Department include:
  - (a) Active Staff members; and

- (b) appropriately credentialed Advance Practice Professionals.

Registered nurses and paramedics may also perform medical screening examinations in the Emergency Department when the Hospital is functioning under surge conditions or during major disasters. *See the Emergency Medical Condition Screening and Transfer Policy.*

- (2) The results of the medical screening examination must be documented within 72 hours of the conclusion of an Emergency Department visit and completed and signed within 14 days. *See the Surge Alert Overcapacity in the ED Policy.*
- (3) Obstetric cases presenting with emergency medical conditions will be handled in accordance with applicable state or federal laws relating to transferring such patients.

<b>Paragraph</b>	<b>Policy Reference</b>
11.C(1)	Emergency Medical Condition Screening and Transfer
11.C(2)	Surge Alert Overcapacity in the ED

## ARTICLE XII

### DISCHARGE PLANNING

#### 12.A. WHO MAY DISCHARGE

- (1) Patients will be discharged only upon the order of the attending physician or another practitioner acting as his/her designee.
- (2) At the time of discharge, the discharging physician will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.
- (3) If a patient insists on leaving the Hospital against medical advice, or without proper discharge, the Hospital policy on discharges against medical advice will be followed and a notation of the incident will be made in the patient's medical record. *See Discharge Against Medical Advice Policy.*

#### 12.B. DISCHARGE PLANNING

- (1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process. *See Discharge Planning Policy.*
- (2) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

#### 12.C. DISCHARGE FROM PACU

Discharge from the post-anesthetic recovery area will be at the discretion of the anesthesia staff overseeing the PACU or designee. At the time of discharge from the PACU, responsibility for patient care reverts to the physician who performed the diagnostic or operative procedure unless the post-procedure orders provide for the transfer of care to a different primary service.

<b>Paragraph</b>	<b>Policy Reference</b>
12.A(3)	Discharge Against Medical Advice
12.B(1)	Discharge Planning

## ARTICLE XIII

### TRANSFERS TO AND FROM OTHER FACILITIES

#### 13.A. ACCEPTING PATIENT TRANSFERS

- (1) When a request is made to accept the transfer of an inpatient from another facility, the patient must have an accepting attending physician. The accepting physician must contact Admissions.
- (2) The Medical Staff physicians (including the Emergency Department physician and staff physicians) shall not refuse to accept requests for transfers if the patient is in need of the specialized capabilities or facilities available at the Hospital. The only exception to this prohibition is if the Hospital lacks the capacity to safely treat the patient. *See Patient Admissions, Transfers, and Discharge (Physicians) Policy.*

#### 13.B. EMTALA TRANSFERS

- (1) The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable policy and in compliance with all applicable state and federal laws, such as EMTALA. *See Emergency Medical Condition Screening and Transfer Policy.*
- (2) Before any such transfer occurs, a physician must see the patient and enter a certification in the patient's medical record indicating that the medical benefits to be received at another medical facility outweigh the risk to the patient of being transferred (including, in the case of a woman in labor, the risks to the unborn child).

#### 13.C. ALL OTHER PATIENT TRANSFERS

##### 13.C.1. General:

The process for providing appropriate care for a patient for all other transfers from the Hospital to another facility includes:

- (a) assessing the reason(s) for transfer;
- (b) establishing the conditions under which transfer can occur;
- (c) evaluating the mode of transfer/transport to assure the patient's safety; and
- (d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

13.C.2. Procedures:

Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:

- (a) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
- (b) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;
- (c) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and
- (d) provide the following information to the patient whenever the patient is transferred:
  - (1) the reason for the transfer;

- (2) the risks and benefits of the transfer; and
- (3) available alternatives to the transfer.

13.C.3. Provision of Information:

When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:

- (a) reason for transfer;
- (b) significant findings;
- (c) a summary of the procedures performed and care, treatment and services provided;
- (d) condition at discharge;
- (e) information provided to the patient and family, as appropriate; and
- (f) working diagnosis.

13.C.4. Patient Requests:

When a patient requests a transfer to another facility, the responsible practitioner will:

- (a) explain to the patient his or her medical condition;
- (b) inform the patient of the benefits of additional medical examination and treatment;

- (c) inform the patient of the reasonable risks of transfer;
- (d) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
- (e) provide the receiving facility with the same information outlined in Section 13.C.3 above.

A patient will not be transferred to another facility unless prior arrangements for admission have been made.

Paragraph	Policy Reference
13.A(3)	Patient Admissions, Transfers, and Discharges
13.B(1)	Emergency Medical Condition Screening and Transfer



## ARTICLE XIV

### HOSPITAL DEATHS AND AUTOPSIES

#### 14.A. DEATH PRONOUNCEMENTS AND REMOVAL OF LIFE SUPPORT

- (1) In the event of a patient death in the Hospital, including a DOA, the deceased will be pronounced dead by the attending physician or his or her designee.
- (2) The determination and documentation of brain death will be made in accordance with the applicable Hospital policy. *See Brain Death Determination and Documentation Policy.*
- (3) 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 discontinued by the responsible physician.
- (4) The declaration of death will be consistent with current state law requirements.

#### 14.B. RELEASE OF THE BODY

No body shall be released from the Hospital without a signed entry in the medical record by the attending physician (or his or her designee), stating the precise time of pronouncement and a signed copy of the death certificate.

#### 14.C. AUTOPSIES

- (1) Coroner Cases.

It is the responsibility of the attending physician (or his or her designee) to notify the Pulaski County Coroner of all deaths. *See Plan for Response to a Patient Death Policy.*

(2) Autopsies Performed in the Hospital.

- (a) If a death is not accepted for coroner's investigation, a hospital autopsy could be considered.
- (b) No autopsy shall be performed without written consent of a legal guardian, relative or other interested person. Such consent must be documented in the medical record.
- (c) A Hospital autopsy should be requested in the following situations:
  - (1) a death which was unexpected;
  - (2) a death in which the cause of death is unclear;
  - (3) a death following significant unexpected changes in the patient's Hospital course;
  - (4) a death of a patient who had been on an investigational protocol;
  - (5) a death which followed a poor or unanticipated therapeutic response;
  - (6) any intraoperative death or death within 24 hours of an anesthetic;
  - (7) any death of a patient receiving patient-controlled analgesia ("PCA") or a continuous epidural infusion of local anesthetics/ narcotics, unless the patient is on comfort care status; and

- (8) an unexpected death within 30 days after surgery.
  
- (d) All autopsies shall be performed by a Hospital pathologist or by a house officer delegated this responsibility and supervised by the attending pathologist. Provisional anatomical diagnoses will be recorded in the medical record within 48 hours, and the complete protocol will be made a part of the record within two months.
  
- (e) The pathologist performing the autopsy will report any unusual or discrepant findings as part of the quality improvement peer review process. This information will be included in the QA Mortality Review process.
  
- (r) It is the responsibility of the patient’s attending physician to assure that the family is informed of the autopsy findings.

**14.D. ORGAN RECOVERY FOR DONATION PROGRAM**

A quarterly report of organ and tissue donation shall be made to the Intensive Care and Patient Care Oversight Committees. *See Routine Referral of Organ and Tissue Donation Policy.*

Paragraph	Policy Reference
14.A(2)	Brain Death Determination and Documentation
14.C(1)	Plan for Response to a Patient Death
14.D	Routine Referral of Organ and Tissue Donation

## ARTICLE XV

### OUTPATIENT CARE SERVICES

#### 15.A. STANDARDS FOR PATIENT FLOW AND SPACE UTILIZATION

Clinic space will be provided based on availability, patient volume, and utilization of allocated space. Community physicians may participate in Hospital-sponsored clinics at the discretion of the chief of service as needs dictate. The Service Chief will work closely with Hospital administration to provide oversight and organize clinic personnel.

#### 15.B. SCHEDULING

Please refer to the Faculty Outpatient Care Guidelines for scheduling process.

#### 15.C. CLINIC CHARTING

All records of patients seen on an outpatient basis shall be incorporated into the patient's Hospital medical record in accordance with the time frames outlined in Section 4.B of these Rules and Regulations. The attending physician shall document the patient's chief complaint and medical history, the findings of the physical examination, medication list, evidence of pertinent previous laboratory evaluations, 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 medications to be administered and specific recommendations to the patient and his or her family. The attending 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 in the letter. The attending physician is expected to communicate with the primary care and referring physician in a timely manner. *See Faculty Outpatient Care Guidelines.*

#### 15.D. QUALITY IMPROVEMENT

Quality improvement activities related to clinics will be addressed by the Outpatient Care and Patient Care Oversight Committees.

15.E. NON-INVASIVE PROCEDURES PERFORMED ON AN OUTPATIENT BASIS

- (1) Patients referred for non-invasive procedures (e.g., MRI, CT) are not required to have a medical history and physical examination completed at the Hospital prior to the procedure.
- (2) Patients who require moderate and deep sedation shall have an appropriate documented pre-sedation history and physical examination consistent with the Hospital policy for use of procedural sedation performed by a practitioner with appropriate privileges. *See Moderate/Deep Procedural Sedation Policy.*
- (3) When applicable and immediately prior to the start of a procedure, the team will perform a time out according to Hospital policy.

Paragraph	Policy Reference
15.C	Faculty Outpatient Care Guidelines
15.E(2)	Moderate/Deep Procedural Sedation

## ARTICLE XVI

### MISCELLANEOUS

#### 16.A. ORIENTATION

All new members of the Medical Staff will be provided an overview of the Hospital and its operations as a part of an orientation process that must be completed by new staff members.

#### 16.B. MEDICAL STAFF PERSONAL CONTACT INFORMATION

- 16.B.1. All members of the medical staff must provide a Primary Personal Contact Number (PPCN) for direct contact that will be published in the hospital online phone book and accessible to the hospital operator and staff. This must be either a number for a personal pager or cell phone based on individual preference. This number will not be published or provided to others outside of the organization.
- 16.B.2. The PPCN cannot be an office number or service/consult pager.
- 16.B.3. All members of the medical staff must provide additional or secondary contact information that will only be accessible to the hospital operators in the event that the medical staff member is on call or needs to be reached emergently, and is not responding in a timely fashion to contact via the PPCN. This secondary contact information must include a personal cell phone number and/or home phone number if applicable.
- 16.B.4. All members of the medical staff must use an Arkansas Children's approved encrypted texting or messaging system when communicating via text regarding patients or patient care.

#### 16.C. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS

##### 16.C.1. Self-Treatment:

Members of the Medical Staff should not treat themselves, or order laboratory or diagnostic tests on themselves, except in an emergency situation or where no viable alternative treatment is available.

##### 16.C.2. Treatment of Family Members:

A member of the Medical Staff should not admit, treat, order laboratory or diagnostic tests, or participate in the surgery of an immediate family member (i.e., spouse, parent, child, sibling, or other relative permanently residing in the same residence as the member), except in the following circumstances:

- (a) no viable alternative treatment is available, as confirmed through discussions with the COS or the CMO;
- (b) the patient's disease is rare or exceptional and the physician is considered an expert in the field;
- (c) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or
- (d) in an emergency where no other Medical Staff member is readily available to care for the family member.

#### 16.D. SPECIAL CARE UNITS

For special care units, such as the Intensive Care Units, the Medical Director of each special care unit will be responsible for adopting specific policies and procedures governing the care of the patients in that unit. These policies and procedures will be reviewed by the Acute Care Committee and approved by the MEC.

#### 16.E. INFECTION PRECAUTIONS

Medical Staff members shall abide by Hospital infection control policies regarding universal precaution to prevent transmission of H.I.V., H.B.V., and other pathogens.

#### 16.F. HIPAA REQUIREMENTS

All members of the Medical Staff and Advance Practice Professionals will:

- (1) adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information; and
- (2) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.



ARTICLE XVII

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XVIII

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: August 8, 2017

Approved by the Board: August 30, 2017

Revisions:

Revisions adopted by the MEC: May 21, 2019

Revisions approved by the Board: May 29, 2019

Revisions adopted by the MEC: January 21, 2020

Revisions approved by the Board: January 29, 2020