Hendrick Medical Center Brownwood

Medical Staff

Rules & Regulations

**ACCESS TO THE MEDICAL RECORD**

1. The medical record shall reside in the HIM Department.
2. On readmission of a patient, records will be available to the attending physician on admission. Records will be taken to the floor or the Emergency Department for a 24-hour period at which time they will be returned to the HIM Department.
3. Free access to all medical records will be afforded to Medical Staff members:
   1. for reference by the physician of record to aid in the care of the patient;
   2. for review by official Medical Staff/Hospital committees;
   3. for bona fide study and research, approved by MEC, consistent with preserving the confidentiality of personal information concerning the individual patient; and
   4. former Medical Staff members, approved by the CAO, shall be permitted access to· the medical records of their patients covering all periods during which they attended patients in the Hospital.

**ANESTHESIA DOCUMENTATION**

1. Before beginning moderate or deep conscious sedation and before anesthesia induction, the anesthesiologist/anesthetic provider is responsible for:
   1. Performing the pre-anesthesia evaluation per Medical Staff policy on pre-anesthesia evaluation
   2. Obtaining informed consent for anesthesia per Medical Staff policy on anesthesia consent
   3. Anesthesia/Sedation monitoring per Medical Staff policy
   4. Post-anesthesia care per Medical Staff policy
2. Patients are discharged from the post-sedation or post-anesthesia recovery area and the organization by a qualified licensed independent Practitioner or according to criteria approved by the Medical Staff.

**AUTHENTICATION OF MEDICAL RECORD ENTRIES**

1. The following individuals are authorized to make entries in the medical record as it applies to their license:
   1. Medical Staff members
   2. Allied Health Professional Staff
      1. Physician Assistant/Nurse Practitioner
      2. CRNA
      3. Psychologist
   3. Hospital employed
      1. Licensed nursing personnel
      2. Physical Therapist
      3. Occupational Therapist
      4. Speech Therapist
      5. Pharmacist
      6. Radiology Technician
      7. Laboratory Technician
      8. Dietitians
      9. Social/Case Workers
      10. Case Managers
      11. Licensed Counselor
      12. Respiratory Therapist
      13. Certified Activity Therapist
      14. Nurse Techs
2. All medical record entries must be legible, complete, dated, timed and authenticated (identified by name and discipline) on entry.
3. All physicians/practitioners must have an "Authenticated Signature" form completed in the HIM Department (Appendix A).
4. Acceptable methods of authentication include:
   1. Written signatures or initials;
   2. Electronic Signature, if the physician has a signed "Notice of Participation for Electronic Signature" on file with the HIM Department per the Hospital Policy regarding Electronic Signature (Policy IM-139).
5. The following medical record entries must be authenticated by the responsible Practitioner:
   1. History and physical examinations
   2. Progress Notes
   3. Orders
      1. Diagnostic and therapeutic
      2. Preprinted
      3. Verbal/telephone
   4. Operative Reports
   5. Consultation Reports
   6. Reports resulting from ancillary/diagnostic testing including but not limited to Pathology, Radiology, EKG, EEG, Echo, Stress Tests, Cardiac Cath, etc.
      1. EKG reads authenticated within 72 hours (amended 6/26/2012)
   7. Discharge Summaries
6. The following medical record entries by the Allied Health Professional Staff must be countersigned by their supervising physician within 24 hours except on the day of discharge:
   1. Orders
   2. Discharge summaries
   3. History & Physical
7. When telephone or verbal orders must be used, they shall be
   1. accepted only by personnel who are authorized to do so per Rule #4, Medical Staff Rules and Regulations for Orders,
   2. dated, timed, and authenticated within 48 hours by the prescriber or another practitioner responsible for the care of the patient.
8. Any physician may sign another physician's order and in doing so will be responsible for that order.

**CONSENT/INFORMED**

1. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.
2. Informed consent must be obtained for:
   1. Operative/invasive procedures as defined in the Hospital Informed Consent policy;
   2. Sterilization permits for Texas Medical Assistance Program patients 30-days prior to the surgery except in cases of emergency cesarean sections;
   3. Delivery upon arrival to Labor/Delivery; and
   4. Autopsy.
3. Prior to surgery performed in the Surgical Unit and prior to performing high-risk invasive procedures on the floor as listed on the back of the Procedure Record (Appendix I), the Practitioner must sign, date, and time the Procedure Record (Appendix I) documenting his discussion with the patient and/or the patient's family of the risks, the hazards, the benefits, and alternatives to the procedure.

**CONTENTS OF THE MEDICAL RECORD**

1. A medical record must be maintained for every individual evaluated or treated in the hospital.
2. To facilitate consistency and continuity in patient care, the medical record contains specific data and information, including:
   1. the patient's name, address, date of birth, and the name of any legally authorized representative;
   2. the legal status of patient's receiving mental health services;
   3. emergency care provided to the patient prior to arrival, if any;
   4. the record and findings of the patient's assessment;
   5. conclusions or impressions drawn from the medical history and physical examination;
   6. the diagnosis or diagnostic impression;
   7. the reasons for admission or treatment;
   8. the goal of treatment and the treatment plan;
   9. evidence of known advanced directives;
   10. evidence of informed consent, when required by hospital policy;
   11. diagnostic and therapeutic orders, if any;
   12. all diagnostic and therapeutic procedures and test results;
   13. tests results relevant to the management of the patient's condition;
   14. all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
   15. progress notes made by the medical staff and other authorized individuals;
   16. all reassessments and any revisions of the treatment plan;
   17. clinical observations;
   18. the patient's response to care;
   19. consultation reports;
   20. every medication ordered or prescribed for an inpatient;
   21. every medication dispensed to an ambulatory patient or an inpatient on discharge;
   22. every dose of medication administered and any adverse drug reaction;
   23. all relevant diagnoses established during the course of care;
   24. any referrals and communications made to external or internal care providers and to community agencies;
   25. conclusions at termination of hospitalization;
   26. discharge instructions to the patient and family; and
   27. discharge summaries, a final progress note or transfer summary.
3. For patients receiving continuing ambulatory care services, the medical record contains a summary list initiated by the third visit and maintained thereafter. The summary list includes:
   1. known significant diagnosis,
   2. conditions,
   3. procedures,
   4. drug allergies, and
   5. medications.
4. Symbols and abbreviations may be used only when approved by the Medical Staff. The approved list will be maintained in the HIM Department.
5. All final diagnosis, including nosocomial infections, must be recorded in full, without abbreviations or symbols
6. The lab section of the medical record shall only contain data from this Hospital, a CAP approved lab, a CUA approved lab or a 1JC approved hospital lab.
7. The content of the obstetrical record must include:
   1. A history and physical, or
   2. A legible copy of the attending physician's current pre-natal record that includes:
      1. a review of systems, and
      2. findings from the last office visit.
8. The content of the Emergency Encounter Record includes:
   1. the patient's name, address, date of birth and the name of any legally authorized representative;
   2. information concerning the time of the patient's arrival, means of arrival and by means of transportation
   3. the legal status of patient's receiving mental health services;
   4. pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to the arrival to the hospital;
   5. description of significant clinical laboratory and radiological findings;
   6. diagnosis;
   7. treatment given;
   8. condition of patient on discharge or transfer; and
   9. final disposition, including instructions given to the patient and/or family, relative to necessary follow-up.

**DELINQUENCY OF THE MEDICAL RECORD**

1. A medical record is considered delinquent when not completed within a specific time frame. A medical record is complete when:
   1. Its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge.
   2. Its contents including any required clinical resume or final progress notes are assembled and authenticated; and
   3. All final diagnoses and complications are recorded without symbols or abbreviations.
2. Practitioners with delinquent medical records shall be automatically placed on "No Admit". When on "No Admit" the Practitioner may not
   1. admit patients except in emergency situations,
   2. schedule or perform any surgical procedures, or
   3. accept any new consultations.
3. A medical record shall not be permanently filed until it is completed by the responsible Practitioner or ordered filed by the Medical Exe01tive Committee and the Board of Trustees.
4. A Practitioner on "No Admit" status will not be exempt from taking Emergency Department Call. Coverage is only extended to unassigned patients.
5. A Practitioner's medical records delinquency rates may also result in automatic action at the time of reappointment as provided in Section 3.3 of the Credentials Policy.
6. Automatic actions do not entitle a Practitioner to any procedural rights of review pursuant to the Fair Hearing or otherwise.
7. A Practitioner may request in writing, a waiver of automatic 'No Admit' status, to the Chief of Staff and Chief Administrative Officer for extenuating circumstances beyond the Practitioner's control.

Examples: The Medical Staff member is waiting for the results of a late report and the record is otherwise complete except for the discharge summary and the final diagnosis; or other delays beyond the control of the Medical Staff member as recognized by the HIM Department and approved by the Chief of Staff and the Chief Administrative Officer.

1. The Chief of Staff and the CAO will have the authority to waive the automatic 'No Admit' status for any or all Practitioners at any time that such a situation arises that prohibits practitioners from efficiently completing their records that are beyond the control of the HIM Department, Hospital or other cause as approved by the Chief of Staff and CAO.

**HISTORY & PHYSICAL**

**Standard:** The history and physical must be completed within 24 hours of admission.

**OPERATIVE REPORT**

**Standard:** Operative reports must be completed within 72-hours post-surgery.

**DISCHARGE SUMMARY & FINAL DIAGNOSIS**

**Standard:** The discharge summary, including the final diagnosis, must be completed within fourteen (14) days post-discharge to allow for transcription and signing within 30 days of discharge.

**Notification of Delinquencies:** Practitioners who have not dictated or handwritten the discharge summary within seven (7) days post-discharge will receive written notification from the HIM Department listing the delinquent medical records and notifying them that they must be completed within the next seven (7) days.

**SIGNATURES/AUIHENTICATION**

**Standard:** The medical record must be completed within thirty (30) days post-discharge.

**Notification of Delinquencies:** Practitioners whose medical records lack signatures/authentications within twenty-three (23) days post-discharge will receive written notification from the HIM Department listing the delinquent medical records and notifying them that they must be completed within the next seven (7) days.

**Delinquency:** Practitioners will be assessed a delinquency for:

* + - Histories & physicals that have not been completed within 24-hours of admission;
    - Operative reports that have not been completed within 72-hours post-surgery;
    - Discharge summaries that have not been dictated or handwritten within 14-days of discharge; and
    - Medical Records that lack signatures/authentication within 30-days post-discharge.

All delinquencies will be included in the overall delinquency rates considered at reappointment.

**No Admit:** All records and/or reports per the notification letter are to be completed by noon on Wednesday. Practitioners will be placed on "No Admit" automatically if all records and/or reports included in the weekly notification are not completed by 8:00 am Monday of the following week they are due.

At a minimum, the MEC will review compliance of this standard on a quarterly basis. A Practitioner placed on "No Admit'' for non-compliance >3 times within a quarter may be subject to disciplinary action.

**EMERGENCY SERVICE REQUIREMENTS**

1. The Medical Executive Committee shall have the overall responsibility of emergency medical care and the authority to ensure that care is provided in accordance with the Hospital's policy for the delivery of such services.
2. Specialties Required to Take Unreferred ER Call
   1. The following specialties are required to take unreferred call in the Emergency Department:
      1. Cardiology
      2. Gastroenterology
      3. General Surgery
      4. Neurology
      5. Obstetrics & Gynecology
      6. Ophthalmology
      7. Orthopedic Surgery
      8. Otorhinolaryngology
      9. Pediatrics
      10. Urology
3. A monthly Physician On-Call calendar will be maintained to reflect the specialties and sub­ specialties available to hospital inpatients. A physician will be eligible for not serving on the call schedule at age 60 with 10 years of service at Hendrick Medical Center Brownwood.
   * + - 1. CALL AVAILABILITY:

Active Staff physician under age sixty (60) will take unreferred ER call a minimum of seven (7) days per month, including at least one weekend. One (1) Friday, one (1) Saturday and one (1) Sunday per month must be included as three (3) of the seven (7) days of required call. Day is defined as a twenty-four (24) hour period.

Nothing would preclude a physician from taking more than one (1) week of call per month.

* + - * 1. NO CALL AVAILABILITY:

The Emergency Department will transfer emergency room patients when there is no physician available for the specialty services needed.

1. **Duty of On-Call Physician to Respond:** The physician on-call has a responsibility to respond, by phone or in person as appropriate to the patient's condition, within 30 minutes.
2. **Duty of On-Call Physicians to Provide Follow-up Care:** The Emergency Department will try to obtain necessary follow-up care with the on-call physician; however, Emergency Department patients will be instructed to return to the hospital to receive the necessary follow-up care if they are unable to obtain follow-up care at the on-call physician's office.
3. **Monthly Schedules:** It is the responsibility of the individual specialty on-call physicians and the single-coverage specialty physicians to forward their Emergency Department On-Call schedule to the designated scheduler at least one week prior to the end of the month to allow time for the preparation and distribution of the hospital call schedule. Any conflicts or disputes will be mediated by MEC.
4. **On-call Duties of a Physician on "No Admit":** Refer to the Delinquency of the Medical Record portion of these Rules and Regulations.
5. **Preference Cards:** Members of the Medical Staff are responsible for providing the Emergency Department with a preference card on how personal patients are to be handled presenting to the Emergency Department. This card is to be updated annually and coordinated by the ER Nurse Manager.

**ORDERS**

1. All orders for admission, treatment and discharge must be in writing or electronically submitted by CPOE. (Approved by BOT on October 26, 2016)
2. On hospital admissions, only the lab work ordered by the physician will be done.
3. Verbal orders may be given by:
   1. Members of the Medical Staff;
   2. Physician Assistants with prescriptive authority and appropriate clinical privileges; and
   3. Advanced Practice Nurses (includes CRNA) with prescriptive authority and appropriate clinical privileges.
4. The following individuals may accept verbal orders as applies to their respective license/ certification:
   1. Licensed nursing personnel;
   2. Physical Therapists;
   3. Respiratory Therapists;
   4. Occupational Therapists;
   5. Speech Therapists;
   6. Pharmacists;
   7. Radiology Technicians;
   8. Laboratory Technicians;
   9. Physician Assistants/Nurse Practitioners;
   10. CRNAs; and
   11. Dietitians.

The use of verbal/ telephone orders is limited but when used may only be given to the licensed staff listed above. After transcribing the order it must be read back to the practitioner to verify accuracy of the order. (Approved by BOT 2/24/2016)

1. The Emergency Department nurse receiving orders for a medication or intervention for a patient presenting to the Emergency Department from a private physician will ask and document the following:
   1. Diagnosis
   2. Has the private physician seen the patient in the preceding 24 hours
   3. Will the private physician be in to the Emergency Department to see the patient

If the answer to (b) or (c) is no, the Emergency Department physician will see the patient prior to any interventions being done.

1. The physician's order must be dated, timed, written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or validated by an appropriate licensed/certified individual as delineated in Rule #4 above.
2. A physician may order that his pre-printed orders be used for a specific patient. The orders will be placed in the medical record for date, time, and authentication by the physician within 48 hours.
3. All previous orders are cancelled when patients go to surgery, including Cesarean Section and post-partum tubal ligation.
4. Drugs that are ordered without time specifications of dosage shall automatically be discontinued as follows:
   1. Vancomycin and Aminoglycoside, Zyvox, and Cubicin................. 4 days
   2. Ketorolac (all formulations)............................................................. 5 days
   3. Sedatives, narcotics and antibiotics.................................................. 7days
   4. All other drugs.................................................................................. 30 days

The physician will be notified prior to discontinuation of a drug. (Approval of BOT 2/24/2016)

1. Oxygen and respiratory therapy will be administered according to physician orders. In those cases where duration of treatment is indefinite or unspecified the physician of record will be notified on the third (3rd) day of treatment for new orders. If no orders are received, treatment will be discontinued on the fourth (4th) day. The physician will be notified prior to discontinuation of oxygen and respiratory therapy.
2. Physical Therapy, Speech Therapy and Occupational Therapy will be administered according to physician orders. The physician will be notified prior to discontinuation of therapy.
3. Transfer of Responsibility of Patient Care: Please refer to the Responsibility of Patient Care portion of the Rules and Regulations.

**PATHOLOGY SPECIMENS**

1. All tissues, including placentas, removed during an operation shall be sent to the hospital pathologist who shall make such examination, as he or she may consider necessary to arrive at a tissue diagnosis.
2. Specifically excluded unless examination is requested by the surgeon are:
   1. Orthopedic appliances, foreign bodies, carious teeth, bone donated to a bone bank and PE tubes, if documented in the record by someone other than the surgeon as to what was removed, counted and measured.
   2. Pacemakers if documented in the record by someone other than the surgeon, measured and/or serial number recorded.
   3. Urinary tract stones submitted for chemical analysis.
   4. Foreskins on routine newborn circumcisions unless specifically requested by the physician. The physician's authenticated report shall be made a part of the patient's medical record.
   5. Scar revisions except in cases of previous malignancy and all redundant skin (i.e. face lifts, blepharoplasty, which do not include skin lesions).
   6. Foreign bodies taken from the OR by law enforcement officers.
3. The following specimens will be sent to pathology for gross examination only, unless the surgeon requests microscopic examination. However, at the pathologist's medical discretion, tissue may be submitted for microscopic examination:
   1. Bone from osteotomies;
   2. Bone segments removed as part of reconstructive procedures;
   3. Bone spurs;
   4. Bunions;
   5. Menisci and joint shavings;
   6. Osteocartilaginous loose bodies; and
   7. Toes removed for functional deformity (e.g. hammer toe).

**RELEASE OF THE COMPLETED MEDICAL CHART AND INFORMATION**

1. The medical chart may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.
2. Unauthorized removal of a medical chart from the hospital is grounds for suspension of the Practitioner for a period to be determined by the Medical Executive Committee.
3. When authorized by the patient or a legally authorized representative, a copy of the emergency services provided will be available to the Practitioner or medical organization providing follow-up care.

**RESPONSIBILITY FOR PATIENT CARE**

1. Only a member of the Medical Staff with admitting privileges may admit a patient to the Hospital.
2. The official admitting policy of the Hospital shall govern all physicians as follows:
   1. Patients will be admitted on the basis of the following order of priorities:
      1. Emergency admissions
      2. Urgent admissions
      3. Pre-operative admissions
      4. Routine admissions
3. A member of the Medical Staff shall be responsible for:
   1. the medical care and treatment of each patient in the hospital,
   2. prompt completeness and accuracy of the medical record,
   3. for transmitting reports of the condition of the patient to the referring physician and to the relatives of the patient.
   4. making rounds on every patient every 24-hours, excluding patients in the Skilled Nursing Unit and Senior Behavioral Health Unit.
      1. Skilled Nursing Unit must be seen by their attending physician every 7 days;
      2. Senior Behavioral Health Unit must be seen by their attending physician 5 of every 7 days. (BOT Approved 8/26/2015)
4. Whenever the primary admitting physician's responsibilities are transferred to another staff member who has been designated by the primary admitting physician as a practitioner who may be called to care for his/her patients at those times the primary admitting physician is not readily available (such as a partner in a designated call group: the physician assuming the responsibilities shall be personally notified and provided with the necessary information in order to ensure continuity of care.

Whenever a primary admitting physician's responsibilities are transferred to another staff member who has not been designated by the primary admitting physician as a practitioner who may be called to care for his/her patients at those times the primary admitting physician is not readily available:

* 1. a note covering the transfer of responsibility shall be entered on the order sheet of the medical record;
  2. a progress note summarizing the patient's condition and treatment should be made in the record; and
  3. to ensure acceptance and understanding of the responsibility for the patient's care, the physician transferring his responsibility shall personally notify the accepting physician. (BOT Approved 10/29/08)

1. Except in an emergency, the admitting physician is responsible for providing an admitting provisional diagnosis or a valid reason for admission prior to any patient being admitted to the Hospital.
2. In an emergency, the admitting physician is responsible for providing an admitting provisional diagnosis or a valid reason for admission as soon as possible.
3. Each physician must assume timely, adequate professional care for his patients in the hospital by being available or having available an eligible alternate physician. Failure of an attending physician to meet these requirements may result in loss of clinical privileges.
4. Patients admitted to ICU must be seen by their attending physician as soon as possible as appropriate depending on the patient's condition but not to exceed 12 hours.
5. Before definitive surgical treatment of malignant disease, the surgeon is responsible for sending a copy of the pathology report for inclusion in the hospital record when pathology diagnoses have been rendered by an outside source.

All females undergoing hysterectomy must have a pap smear report in the medical record no more than 12 months old dating back from the scheduled date of the surgery.

1. The attending physician is responsible for documenting the need for continued hospitalization after specific periods of stay.

Upon request the attending physician must provide written justifications of the necessity for continued hospitalization of any patient hospitalized twenty (20) days or longer including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

1. The determination of the cause of death and the signing of the death certificate are responsibilities of the physician and cannot be delegated to other non-licensed persons.
   1. The physician may delegate the pronouncement of death to a Registered Nurse (RN) or a Physician Assistant (PA) as allowed by their respective Practice Act/Governing Board.
   2. The physician or designee will make an entry in the medical record stating the time of death.
   3. Nursing Service will then release the body at the direction of the family member(s).
   4. If an autopsy is requested, the hospital personnel will assist in coordinating such service for the physician/family.

**SURGICAL CARE - GENERAL RULES**

**GUIDELINES FOR ANESTHESIA PRE-OPERATIVE TESTING**

Our policy will be:

1. To do tests upon indication of disease.

**RULES**

1. Surgeons should be in the operating room and ready to commence operation at the time scheduled. Surgeons with 7:30 am surgery should be in the OR by 7:15 am and not later than 7:30 am. If the surgeon is late 3 times in one month his 0730 privilege may be suspended for 1 month at the Chief of Surgery's discretion (REVISION APPROVED BY BOT 4/20/05)
2. If, in the opinion of the operating surgeon and/or the chief of surgery, there is in any surgical procedure an unusual hazard to life, there will be present and scrubbed as first assistant a physician designated by the credentials committee as being qualified to assist in major surgery.
3. The rules for the scheduling of elective or non-emergency surgery will be as follows:
   1. Surgical cases can be posted on the surgery schedule from 7:00 am to 5:30 p.m. weekdays. Add-ons and emergency cases are to be posted with the House Supervisor. {REVISION APPROVED BY BOT 4/20/05)
   2. The following information is required in order to post a case:
      1. The patient's full name unless specified only the last name
      2. Age
      3. Sex
      4. Operation
      5. Type of Anesthesia
      6. Operating Surgeon
      7. Time and name of person posting the case
      8. Assistant surgeon if known

The assistant surgeon should be named at any time prior to the time of the case and if none is designated should be so indicated. The operating surgeon will be notified regarding the name of the assistant on the day prior to surgery and again will be called at 6:30 am for the name of the assistant surgeon.

* 1. After the 7:30 am time slots are filled the order of the cases will be based on the time of the cases posted, availability of assistant surgeon, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.
  2. If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they don't interfere with the normal operating room schedule.

These cases will be scheduled in accordance with rule number (c) and will be done as near to that time as a room is available in the order the case is posted. The time may be changed if it doesn't interrupt the normal schedule as determined by the Chief of Surgery.

1. If a conflict between the operating surgeon and anesthesia occurs, the Chief of Anesthesia and Chief of Surgery will be notified. Their mutual decision will be binding. If no mutual decision is made, the Chief of Staff's decision will be binding.
2. General rules regarding emergency outpatient surgery in the operating room of the hospital:
   1. The surgery is to be arranged through the emergency room.
   2. The patient is admitted to the emergency room pre-operatively.
   3. Patient will either go to the recovery room and be discharged from there or be discharged directly home from an assigned room.
3. Elective outpatient surgery is scheduled like any other surgical case.
4. Patients may be transferred or discharged from the recovery room when discharge criteria have been me
5. **SCHEDULING**

a. Block times are relinquished at noon two working days prior to the scheduled day; therefore, surgeons with block times that have been relinquished may not follow themselves with add-on cases just because it is their block day. Their add-on case will be handled as all add-on cases are handled, on a first-come, first-serve basis.

b. Surgeons may not substitute one case for another. If the surgeon feels a case is an emergency it must be declared as such and the surgeon is responsible for calling all physicians who will be affected by the delay.

c. **No elective** surgeries will be scheduled when it is anticipated that they will not be completed by 3:00 PM.

d. There will be no Day Surgery scheduled or performed on the weekends, excluding post­ partum BTL.

e. Cases will be completed as scheduled, even if the scheduled morning cases flow over into the afternoon.

**Surgeons** with block times must fill their blocks before scheduling cases in the open time. A block is considered full if scheduled from 7:30 AM to 12:30 PM. After 12:30 PM the block is open unless the surgeon's schedule continues past 12:30 PM. The surgeon has the option to work until 3:00 PM.

1. **MOVING TIIE PATIENT INTO THE ROOM**
   1. The OR staff will call the surgeon when the patient is ready to be moved in the room.
   2. If the surgeon agrees the patient will be moved into the room, placed on the OR bed and monitors placed by anesthesia.
   3. At the discretion of the anesthesiologist, anesthesia can commence with the induction of anesthesia if the surgeon is readily available. Readily available is defined as within 5-10 minutes. This applies to all surgeons.

This procedure will be discontinued on an individual basis if patients are kept waiting an excessive time in the operating room for the arrival of their surgeon.

**OBSTETRICS**

10. All patients shall have CBC, UA and RPR on admission.

11. All patients shall have type and Rh results on their chart prior to discharge. The physician is responsible for sending a copy of the type and Rh results for inclusion in the hospital record when they have been rendered by an outside source.

12. All patients shall have post-partum hemoglobin and hematocrit prior to discharge.

13. Patients who are going to undergo caudal, spinal, saddle block, epidural, or general anesthesia should have an IV started prior to the administration of anesthesia.

**TERMINATION OF PREGNANCY**

1. Termination of Pregnancies will be handled in the following manner:
   1. Pregnancies will not be terminated in this hospital solely on patient's request or demand.
   2. Termination of pregnancies may be done for therapeutic reasons.
   3. The reasons for the termination pregnancy must be clearly documented in the medical record.
   4. Prior to terminating a pregnancy, a consultation is required with 2 physicians who are members of the Active Medical Staff.