

# Children's

HOSPITAL • ST. LOUIS

**BJC** HealthCare<sup>SM</sup>

# MEDICAL STAFF RULES & REGULATIONS

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## **ARTICLE I - ADMISSIONS**

### **Section 1: Who May Admit Patients**

Patients may be admitted to the Hospital only by Active members of the Medical Staff. Patients shall be assigned to the Department and/or Division concerned in the treatment of the condition which necessitated admission. Every patient admitted to the Hospital must have a designated Medical Staff member who is responsible for his/her care. Patients presenting for admission who have no personal physician/dentist shall be assigned an attending physician/dentist.

### **Section 2: Responsibilities of Admitting Physician/Dentist**

Information pertinent to the patient's general health as well as information necessary to protect the patient and others from harm shall be provided by the admitting physician/dentist.

### **Section 3: Provisional Diagnosis Requirements**

Except in emergency, no patient shall be admitted to the Hospital until after a provisional admitting diagnosis has been made and recorded in the medical record. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

### **Section 4: Required Pre-Admission/Admission Tests**

The requirement for pre-admission tests is based on the needs of individual patients. Each patient admitted to the Hospital shall have diagnostic studies performed as necessary for the diagnosis and treatment of his/her condition.

## **ARTICLE II - ATTENDING PHYSICIAN/DENTIST**

### **Section 1: Responsibilities of Attending Physician/Dentist**

#### a) Physician

The attending physician shall be responsible for the medical care and treatment of his/her patient, for prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the patient's condition to the referring physician, other relevant care providers and the parent(s)/guardian of the patient. The attending physician shall also be responsible for the medical supervision of all who participate in the delivery of care for his/her patient.

#### b) Dentist

The attending dentist shall be responsible for the care and treatment of his/her patient, for prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the patient's condition to the referring physician/dentist, other relevant care providers and the parent(s) guardian of the patient. Attending dentists shall have the same responsibilities as physicians except that, at all times, the patient's general medical condition shall be the responsibility of a physician. See Article VII Dental Care, Section 2 of these Rules and Regulations.

## **ARTICLE III - COLLABORATIVE PRACTICE ARRANGEMENTS**

### **Section 1: Definition**

Collaborative practice arrangements may be entered into by physicians and advanced practice nurses (“APN”). Such arrangements shall be established through written agreements for the delivery of health care services and must include the approval of the appropriate Department Chair of Washington University School of Medicine and the President of the Hospital.

Collaborative practice agreements authorize advanced practice nurses to provide assessments, diagnosis, treatment, and to prescribe, administer and dispense drugs as the delivery of such health care services is within the scope of practice of the advanced practice nurse and is consistent with that nurse’s skill, training and experience. Collaborative practice arrangements do not, however, authorize advanced practice nurses to prescribe controlled substances.

### **Section 2: Definition - Advanced Practice Nurse in Collaborative Practice**

An advanced practice nurse is a registered nurse who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Missouri State Board of Nursing. Advanced practice nurses will be credentialed and approved by the medical staff organization in accordance to the administrative policy entitled “Advanced Practice Nurse Credentialing”.

Use of the term “advance practice nurse” in the Medical Staff Rules and Regulations refers to those advanced practice nurses who have entered a collaborative practice arrangement at St. Louis Children’s Hospital and who have received a Document of Recognition from the State Board of Nursing in accordance with 4 C.S.R. 200-4.100.

### **Section 3: Relationships between APNs and Attending Physicians**

When an APN in collaborative practice has been delegated responsibility by his or her collaborating physician to care for a patient, it remains the collaborative physician’s responsibility to coordinate the patient’s care with any other attending physician responsible for the patient.

## **ARTICLE IV - INFORMED CONSENT**

### **Section 1: Definition**

“Informed consent” means consent obtained by a physician, an advanced practice nurse or dentist from the patient, his/her parent(s) or legal guardian based on discussion of the nature, benefits, significant risks and alternatives to the proposed treatment, care or services.

### **Section 2: Responsibility of Obtaining Informed Consent**

At the time of admission or as soon thereafter as practical, the Hospital’s standard admission consent form(s) must be obtained and signed by the parent(s) or legal guardian or, when appropriate, by the patient. The admitting department shall notify the attending physician/dentist whenever such consent has not been obtained.

After admission, it shall be the responsibility of the appropriate physician/dentist to obtain consent from the patient, his/her parent(s), legal guardian, or other authorized representative, e.g. individual authorized under durable power of attorney for healthcare decisions in, but not limited to, the following circumstances:

1. The surgeon shall obtain the consent to any surgical procedure to be undertaken, including ambulatory surgery;
2. The physician/dentist performing any special diagnostic procedure shall obtain the consent for such non-routine or high risk medical procedures;
3. Autopsy consent;
4. Protocol for research purposes;
5. Organ donation.
6. In cases requiring anesthesia, the anesthesiologist shall obtain consent for administration of the anesthesia.
7. In cases requiring sedation, the physician, dentist, APN or specially trained registered nurse shall obtain consent for administration of sedation.

An advanced practice nurse in collaborative practice who performs procedures may obtain informed consent for procedures the APN will perform.

Except in emergencies, no procedure shall be performed without a documented consent in the patient's medical record prior to the performance of the procedure. Oral consents are permitted if obtained by a physician/dentist and witnessed by a licensed health care professional. Such oral consents must be documented in the medical record.

### **Section 3: Emergency Care and Treatment Without Consent**

1. Emergency care and treatment may be provided to a patient without consent when, in the judgment of the treating physician/dentist, any delay may increase the risk to the patient's life, health, mental health or welfare, or unduly prolong suffering. In such cases, the treating physician/dentist shall document in the patient's medical record the reasons for rendering care without consent. If the treating physician/dentist is a resident or fellow, the note shall be countersigned by the attending physician/dentist.
2. When emergency treatment (other than surgery or special procedures) is begun without parental or guardian consent, attempts to reach the parent(s) or legal guardian by telephone shall be initialed as soon as possible. Telephone consent from a parent or legal guardian of the patient is permissible in such circumstances as long as it is obtained by physician/dentist and witnessed by a licensed health care professional. Telephone consent must be documented in the medical record and signed by the physician dentist and the witness.

### **Section 4: Duration of Validity of Informed Consent**

Signed consent is valid for the duration of an admission unless significant change in the patient's condition warrants consent based on new information. Signed consent for outpatient procedures is valid unless there has been significant change in the patient's condition since consent was first obtained.

## **ARTICLE V - CONSULTATIONS**

### **Section 1: Required Consultations**

Consultation shall be obtained whenever the responsible physician or other responsible practitioner believes that such consultation may prove beneficial to the patient, when the patient's condition requires expertise beyond the scope of the responsible practitioner, or if appropriate, at the request of the parent or legal guardian.

### **Section 2: Definition of a Consultant**

Members of the Medical Staff or their designees may serve as consultants. In special situations, qualified practitioners not on the Medical Staff who have been granted temporary privileges may be invited to visit patients in the Hospital and advise the requesting practitioner, as well as observe the course of treatment. Such consultants may not assume responsibility for the patient; responsibility for the patient remains with the attending physician/dentist.

### **Section 3: Composition of Consultations**

A consultation includes an examination and/or observation of the patient, review of the record and timely communication with the requesting physician/dentist. A written opinion signed by the consultant must be included in the medical record. If a medical/psychiatric consultation is performed by a designee who is not a member of the Medical Staff, it must be countersigned by a member of the active Medical Staff. When operating procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

## **ARTICLE VI - DEATHS**

### **Section 1: Pronouncement of Death**

Death is officially pronounced by a physician and documented in the medical record. Documentation shall include the events leading to the death, date and time the patient was pronounced dead and the signature of the physician and his/her appellation.

### **Section 2: Determination of Brain Death**

Brain death shall be determined in accordance with current St. Louis Children's Hospital policy, attached as Exhibit 1.

### **Section 3: Reporting of Deaths to the Medical Examiner**

Physicians shall report deaths of children fifteen years and under to the St. Louis City or County Medical Examiner in accordance with the State statute. In addition, State statute requires reporting of death as a result of:

A. Violence by homicide, suicide or accident;

- B. Thermal, chemical, electrical, or radiation injury;
- C. Criminal abortion including those self-induced;
- D. Disease thought to be of a hazardous and contagious nature or which may constitute a threat to public health; or
- E. When any person dies
  - 1. Suddenly when in apparent good health,
  - 2. When not attended by a physician, chiropractor or an accredited Christian Science practitioner during the period of thirty-six hours immediately preceding the death,
  - 3. While in the custody of the law or while an inmate in a public institution, or
  - 4. In an unusual or suspicious manner.

#### **Section 4: Autopsies**

It shall be the duty of all physicians/dentists to request consent for autopsy in the following situations (as recommended by The College of American Pathologists):

- A. Deaths in which autopsy may help to explain unknown and unanticipated medical complications.
- B. Deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
- C. When the autopsy may help to allay concerns of the family, physicians and/or the public regarding the death.
- D. When unexpected or unexplained deaths occur during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
- E. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (1) persons dead on arrival at hospitals, (2) deaths occurring in hospitals within twenty-four (24) hours of admission, and (3) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- F. Deaths resulting from high-risk infectious and contagious diseases.
- G. All perinatal and pediatric deaths.
- H. Deaths at any age in when it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
- I. Deaths known or suspected to have resulted from environmental or occupational hazards.

### **ARTICLE VII - DENTAL CARE**

#### **Section 1: Oral and Maxillofacial Surgeons**

Qualified oral and maxillofacial surgeons may perform the history and physical examination in accordance with their delineated privileges. Patients with medical problems outside the scope of the oral and maxillofacial surgeon's expertise require joint evaluation and management with a physician.

## **Section 2: Other Dental Specialists**

Services not requiring general anesthesia may be provided by the dental specialist who is responsible for the dental-related history and physical examination and for administration and monitoring of local anesthesia and sedation in accordance with the St. Louis Children's Hospital Medical Staff policy on sedation.

Services requiring general anesthesia require a history and physical examination performed by a physician as specified in the Surgical Care section of this document. Patients with medical problems require joint evaluation and management with a physician. See Article II Attending Physician/Dentist, Section 1.b of these Rules and Regulations.

## **ARTICLE VIII - DISCHARGES**

### **Section 1: General**

At the time of discharge, the medical record must reflect all relevant diagnoses and operative procedures performed and an assessment of the patient's needs for services after hospitalization. Discharge instructions, prescriptions and any referrals should be finalized and reviewed with the patient and family/adult care provider prior to discharge.

### **Section 2: Leaving Against Medical Advice**

If a patient leaves the Hospital against the advice of the physician/dentist, or without proper discharge, a notation of the incident shall be made in the patient's medical record. When possible, the patient or family/adult care provider shall be asked to sign the Hospital's release form.

## **ARTICLE IX - EMERGENCY SERVICES**

### **Section 1: General**

The Emergency Unit provides initial evaluation and treatment to pediatric patients seeking unscheduled care at St. Louis Children's Hospital for medical, dental and/or surgical problems. All patients presenting to the Emergency Unit will receive a medical screening examination to determine whether an emergency condition exists. This exam will be performed by a registered nurse, an advanced practice nurse (including pediatric nurse practitioner), or a physician. An attending physician or designee will be available at all times for consultation regarding medical screening examinations. Specifics regarding Emergency Unit physician's responsibilities and coverage, documentation, consent to treatment, collaborative practice arrangements and admission to the Hospital are enumerated in the Emergency Unit policy and procedure manual. The contents of such manual shall be developed by the Emergency Unit Policy and Procedure Committee and approved by the Children's Medical Executive Committee.

### **Section 2: Coverage**

At least one (1) physician shall be on duty twenty-four (24) hours per day, seven (7) days per week to provide emergency services.

Each Department Chief is responsible for providing call lists of House Staff and/or attending physicians on duty or on call to respond to calls from the Emergency Department. On-call or on-duty physicians taking emergency call shall arrive at the Emergency Department within thirty (30) minutes of being summoned. The Trauma attending physician on-call or on-duty shall arrive at the Emergency Department within twenty (20) minutes of being summoned.

## **ARTICLE X - INTENSIVE CARE UNITS**

### **Section 1: Admission and Discharge Criteria**

Admission to and discharges from the intensive care units shall be in accord with the policies and procedures reviewed by the appropriate hospital and medical staff leaders and approved by the Children's Medical Executive Committee.

## **ARTICLE XI - MEDICAL RECORDS**

### **Section 1: History and Physical**

1. Inpatient History and Physicals: For patients admitted to the hospital for in-patient services, a physician or appropriately authorized APNs, physician assistants and medical student may perform a history and physical examination. The supervising or precepting physician for the non-physician practitioner performing the history and physical examination must sign and retains full responsibility for the history and physical examination. An inpatient history and physical examination must be performed and documented within 24 hours after the patient's admission. The documentation of a history and physical must include, when pertinent:

- a. the chief complaint;
- b. history of present illness;
- c. past medical history;
- d. family history;
- e. psychosocial history;
- f. review of systems, including medication and allergies
- g. physical examination;
- h. provisional diagnosis or clinical impression;
- i. treatment plan.

For Dental admissions, the history and physical examinations must include:

- a. chief complaint;
- b. details of disease;
- c. injury and/or defect of the jaws and/or contiguous structures; and
- d. its implications on the patient's general health.

If a member of the Medical Staff performed a history and physical examination within 30 days prior to a patient's admission to the hospital, a reasonably durable, legible copy of the history and physical report may be used for the patient's current hospital admission, provided that the attending physician or other authorized individual within 24 hours of admission examines the patient, documents any additions to the history or changes in the patient's current physical findings and signs the history and physical examination.

2. Surgery and Outpatient History and Physical Examination Requirements. For patients receiving surgical or outpatient services such as surgery and diagnostic procedures requiring regional or general anesthetic or sedation, a physician or appropriately authorized APNs, physician assistants and medical student may perform a history and physical examination. A history and physical examination must be performed and documented within 30 days prior to the surgery/procedure confirming the necessity for the procedure and must be present in the medical record prior to surgery/procedure, excepting emergency surgeries. The documentation of a surgical or outpatient history and physical examination must include, at the minimum:

- a. pertinent prior medical history;
- b. review of current medications and allergies, if any;
- c. pertinent physical exam, including heart rate, respiratory rate and blood pressure; and
- d. indication for the procedure.

When the history and physical examination is not recorded before the time stated for the surgery/procedure, the surgery/procedure shall be cancelled or, when feasible, delayed until the history and physical examination is documented unless the attending physician states in writing that such delay would constitute a hazard to the patient.

If a member of the Medical Staff performed a history and physical examination within 30 days prior to a patient's outpatient surgery/procedure, a reasonably durable, legible copy of the history and physical report may be used for the patient's current hospital admission, provided that the attending physician or other authorized individual examines the patient prior to the surgery/procedure, documents any additions to the history or changes in the patient's current physical findings and signs the history and physical examination.

All notes written by medical students must be countersigned, and amended, if necessary, by the responsible licensed preceptor physician, who is either a member of the House Staff or the Attending Physician. These rules govern all medical student clinical preceptorship assignments, whether entitled "clinical clerkship," "externship" or any other term that might be used.

## **Section 2: Progress Notes**

Progress notes must be recorded by the physician/dentist, medical student, physician assistant, and advanced practice nurses in a collaborative arrangement to ensure continuity of care and document the patient's problems, progress and assessment. Progress notes written by medical students and physician assistants must be co-signed by a licensed physician if no other entries are written that day by a physician.

## **Section 3: Operative Notes**

The attending surgeon or his/her designee will write an operative progress note in the medical record immediately following the completion of the operation or procedure and before the patient is transferred to the next level of care; unless the surgeon or his/her designee accompanies the patient from the operating room to the next unit or area of care where he/she will write the operative progress note.

The operative progress note shall contain: (1) the name of physician and assistant(s); (2) procedure(s) performed including description of that procedure and complications, if any; (3) findings; (4) estimated blood loss; (5) specimens removed; and (6) pre- and postoperative diagnoses.

The attending surgeon or his/her designee will dictate an operative report immediately following the operative procedure. The operative report shall contain the elements listed above as well as the patient name and hospital identification number, date and times of surgery/procedure, description of surgical technique; type of anesthesia administered, and any prosthetic devices, grafts or devices implanted. The attending surgeon will sign or countersign the dictated operative report.

#### **Section 4: Procedure Notes**

A written procedure note shall be recorded in the progress notes immediately following the procedure. The procedure note shall contain indications for the procedure, findings, a description of the procedure and specimens obtained, pre- and post-procedure diagnoses and the name of the physician/dentist, advanced practice nurse in collaborative arrangement, and his/her assistants.

#### **Section 5: Discharge Summaries**

A discharge summary shall be documented in the patient's medical record within thirty (30) days of the patient's discharge consistent with the Medical Record Delinquency Policy, attached as Exhibit 3. All discharge summaries shall include: 1) the reason for hospitalization; 2) significant findings; 3) complications; 4) procedure(s) performed and treatment(s) rendered; 5) condition of patient at discharge; and 6) instructions given to the patient and/or his/her family members. A discharge summary may be documented by Medical Staff members, House Staff, APNs in collaborative practice or Physician Assistants within supervision agreements as determined by the respective Department Chief. The Medical Staff member, House Staff or APN shall sign the summary, either electronically or by hand. A copy of the hospital discharge summary will be sent to the admitting and/or referring physician or practitioner.

A final progress note or discharge note may be substituted for the discharge summary in the case of patients with problems of a minor nature as defined by the Medical Staff and who require a hospital stay of less than 48 hours. The final progress or discharge note shall include diagnoses, medications, physical limitations, if any, special diets, discharge instructions and instructions for follow-up.

#### **Section 6: Symbols and Abbreviations**

Only those symbols and abbreviations recommended by the Health Information Management Subcommittee and approved by the Children's Medical Executive Committee shall be used. A copy of this list shall be placed on file in the Health Information Management Department.

#### **Section 7: Access and Confidentiality of Records.**

All records are the property of the Hospital and the original may only be removed by court order, subpoena, for microfilming or for offsite storage. Records may accompany patients who require medical care in other parts of the medical center. Copies shall be provided only as authorized by state law. Access to medical records by all others may be had only by authorization of the patient, the patient's parent or legal guardian, or the executor of the patient's estate. Such authorization must be renewed at the end of ninety (90) days. All physicians, dentists and advanced practice nurses who provided care to the patients may review the medical records on those patients. Physicians/dentists may have access to medical records for bona fide study and research consistent with preserving the confidentiality of the patient.

### **Section 8: Delinquency**

All medical records shall be completed within 30 days after discharge. If the medical record is not completed 30 days after discharge, it shall be considered delinquent pursuant to the Medical Record Delinquency Policy. Report of the delinquent record is made to the responsible physician with a copy sent to the respective department chief and the Health Information Management Subcommittee. The department chief and/or appropriate division director is held responsible for the completion of the delinquent record. No medical record shall be filed until it is complete except on the order of the Health Information Management Subcommittee pursuant to the Medical Record Delinquency Policy. (See Exhibit 2) Physicians/dentists who fail to complete medical records within the allotted time are subject to disciplinary action.

### **Section 9: Medical Student Notes**

Histories and physicals and orders written by medical students must be reviewed and countersigned, and amended if necessary, by the student's supervising physician prior to being acted upon or implemented.

### **Section 10: Computerized Patient Record & Electronic Signature**

The use of the computerized patient record and electronic signature and related policies shall be recommended by the Health Information Management Subcommittee and approved by the Children's Medical Executive Committee.

## **ARTICLE XII - ORDERS**

### **Section 1: Medications**

Medications may be administered by, or under the supervision of, licensed personnel in accordance with Missouri State law. Medications will be dispensed to patients only upon a physician, advanced practice nurse in collaborative practice, physician assistant with a supervision agreement or dentist's order. Generic drug names are preferred in writing medication orders; all medication orders must comply with the standards outlined in the Safe Prescribing Policy (see Exhibit 7).

The Pharmaceutical, Diagnostics & Therapeutics Subcommittee shall be responsible for the formulary of medications used in the Hospital, and the addition, restriction or deletion of drug products from the formulary. Medication must be listed in the latest edition of Approved Drug

Products with Therapeutic Equivalence Evaluation (U.S. Department of Health and Human Services, Food and Drug Administration), or Facts and Comparison to be considered by the Subcommittee, with the exception of drugs prescribed for bona fide clinical investigations. Exceptions to these rules must be approved by the Pharmaceutical, Diagnostic & Therapeutics Subcommittee.

The Pharmacy may dispense a generic or chemical equivalent for medications in accordance with state and federal laws, unless the proprietary name of the medication is used, followed by the words “No Substitute.”

The Pharmaceutical, Diagnostics & Therapeutics Subcommittee shall adopt specific regulations for other aspects of medication procurement, storage, distribution, dispensing, administration, documentation and disposal. These regulations are subject to approval of the Children’s Medical Executive Committee.

### **Section 2: Pre-printed Order Sheets**

Pre-printed order sheets shall require the approval of the Health Information Management Subcommittee prior to use. Such orders shall not supersede specific orders written by physicians, advanced practice nurses, physician assistants or dentists. The pre-printed forms shall always be signed and dated by the physician, advanced practice nurse, physician assistant or dentist.

### **Section 3: Verbal and Telephone Orders**

In an effort to minimize miscommunication of orders, St. Louis Children’s Hospital strongly encourages the use of written orders from physicians and other practitioners authorized to write such orders when they are present in the hospital, or provide written orders via remote means.

Verbal or oral telephonic communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible and sound medical practice dictates the institution of therapy prior to the time in which a written order can reasonably be provided by the physician or practitioner.

Verbal or telephone orders for medications shall be given only to registered nurses, respiratory therapists, (for respiratory-related medications only), transport team paramedics (under the direction of the transport physician or nurse) or to pharmacists. Verbal and telephone medication orders must be given and written using the Safe Prescribing Policy stated in Exhibit 7 of these Medical Staff Rules and Regulations. Physicians and other practitioners shall communicate orders unrelated to medications only to licensed, registered or certified professional individuals within the scope of such individual’s specialty.

In order to verify and validate the order, the person receiving the verbal or telephone order will write down, then read back to the prescriber or individual transmitting the order. The person receiving the verbal or telephone order will document the order in the patient’s medical record specifying whether it is a verbal or telephone order and signing his/her name and title in accordance to hospital policy.

The prescriber or his/her designee (as permitted by these Rules & Regulations) will sign all verbal and telephone orders within 48 hours of the order being given. The prescriber, or his/her designee, should review orders daily and should countersign as soon as possible, especially before patient transfer to another medical/surgical service.

#### **Section 4: Do Not Resuscitate Orders**

Do Not Resuscitate orders written in accordance with the protocol developed by the Children's Medical Executive Committee and approved by the St. Louis Children's Hospital Board of Trustees may be implemented upon written order on the physician's order sheet. (Exhibit 3)

#### **Section 5: Automatic Review Orders**

An automatic review of antibiotics and Schedule II controlled substances orders is established by the Pharmaceutical, Diagnostics & Therapeutics Subcommittee and approved by the Children's Medical Executive Committee, except in cases where the physician, advanced practice nurse in collaborative practice, physician assistant (excluding order for controlled substances) or dentist states a specific number of days or doses in the order.

Pharmacists shall review patient medication orders and discuss with the physician, dentist or advanced practice nurse the need to continue the medication.

All medications not listed in the above categories shall also be reviewed by the pharmacist for appropriateness of continuing therapy.

All medication orders shall be automatically canceled when the patient goes to surgery.

#### **Section 6: Medications Brought from Home**

Patients may not use medications that are not dispensed from the St. Louis Children's Hospital Pharmacy with the exception of:

1. Investigational drugs which are kept by the patient or parent/guardian;
2. Total Parenteral Nutrition (TPN) solutions
3. Oral contraceptives

Other exceptions may be made to this list by the Pharmaceutical Diagnostics & Therapeutics Subcommittee.

When patients are allowed to take medications (one of the above exceptions) that they have brought into the Hospital, the physician/dentist must write an order to "administer patient's own medication" with an indication of the medication, dose, route and frequency. Such medications shall be stored in the medication area of the nursing unit, under appropriate storage conditions. Administration of such medications shall be documented according to policy. The identification and potency of medications brought from home shall be the responsibility of the attending physician/dentist or house officer.

Any medication that is brought by patients to the Hospital, but is not one of the above exceptions, shall be returned to the parents/legal guardian with instructions to take the medications home.

### **Section 7: Self-Administration of Medications**

A physician, advanced practice nurse or dentist must enter a written order for self-administration of medications in the patient's medical record.

### **Section 8: Special Treatment Procedures**

Documentation is necessary in the patient's medical record for special treatment procedures. Psychiatric restraint or seclusion or behavioral modification procedures that use aversive condition require written orders and time limitations in the patient's medical record.

### **Section 9: Advance Directives**

Advance Directives may be utilized in accordance with the policy adopted by the Children's Medical Executive Committee, attached as Exhibit 4. A copy of the directive shall be placed in the patient's medical record.

## **ARTICLE XIII - SURGICAL CARE**

### **Section 1: Surgery**

A history and physical, pre-operative diagnosis and appropriate lab test results must be recorded in the patient's medical record prior to any surgery. Outpatients must be provided with written instructions for follow-up care.

### **Section 2: Presence of Attending Surgeon**

The patient will not enter the operating room until the attending surgeon is present on the hospital grounds or not further than a five minute walk to the operating room. Any exception to this rule requires the approval of the attending anesthesiologist. The attending surgeon must be present during the critical portion of the case.

### **Section 3: Emergency Surgery**

In emergencies, surgery can be performed before a full pre-operative work-up is completed, provided the surgeon documents in writing that delay would cause a hazard to the patient.

### **Section 4: Surgical Specimens**

Specimens removed during a surgical procedure are ordinarily sent to the pathologist for evaluation. The medical staff, through the Surgical Services Subcommittee and in consultation with the pathologist, decides the exceptions to sending specimens removed during a surgical procedure to the laboratory. Surgical specimens may be used for research purposes in accordance with the state and federal law, and only with appropriate consent.

## **ARTICLE XIV - ANESTHESIA**

### **Section 1: Pre-Anesthesia Evaluations**

Pre-anesthesia evaluations must be performed in accordance with Standards for Sedation and Anesthesia (Exhibit 6) within 48 hours of a planned anesthetic and documented in the anesthesia record. The anesthesiologist shall review the patient's condition immediately prior to the induction of anesthesia, and any changes in patient condition or anesthetic plan will be noted in the medical record.

### **Section 2: Parameters of Care**

Record keeping, monitoring and equipment safety verification will be carried out in accordance with the recommendations published by the American Society of Anesthesiologists.

### **Section 3: Post-Anesthesia Evaluations**

A patient may be discharged from the Post Anesthesia Care Unit by an anesthesiologist or designee, or when patient meets pre-determined criteria which have been approved by the Department of Anesthesiology, the Surgical Services Subcommittee and the Children's Medical Executive Committee. A post-anesthesia note shall be entered into the medical record within 24 hours after surgery reflecting evidence of the patient's present physical condition, tolerance to anesthesia, and any unusual events or post-anesthesia complications and the management of any such event or condition.

### **Section 4: Sedation**

Sedation within the Hospital shall be carried out in accordance with the current guidelines described in the Procedural Sedation Guidelines (Exhibit 8).

## **ARTICLE XV - TRANSFERS**

### **Section 1: Transfer of Attending Physician/Dentist Responsibility for In-House Transfers**

Whenever attending physician/dentist responsibilities are transferred to another attending physician/dentist or clinical service, an order for the transfer of responsibility is documented.

### **Section 2: Transfers in Emergency Situations**

Designation of the chief medical officer and specific transfer protocols are contained in the Hospital's Emergency Preparedness Manual.

### **Section 3: Transfers Out of the Facility**

It shall be the responsibility of the transferring physician/dentist to make arrangements with the accepting physician/dentist and Administration of the accepting Hospital. Transfers shall be carried out in accordance with applicable state and federal guidelines (EMTALA). All pertinent medical information shall accompany the patient.

## **ARTICLE XVI - PREGNANT PATIENTS**

### **Section 1: Treatment**

Except in an emergency, patients known to be pregnant are not admitted for treatment of pregnancy. Patients known to be pregnant or discovered to be pregnant may be treated for illness or injury unrelated to pregnancy with consultation by an obstetrician as indicated or they may be transferred according to applicable transfer procedures.

## **ARTICLE XVII - HOUSE STAFF**

### **Section 1: Definition**

The House Staff shall consist of interns, residents, clinical fellows and research fellows. House Staff will not be considered members of the Medical Staff, and will only have those rights specifically set forth in this Section, and as explained in more detail in the Procedure for Review of Academic and Disciplinary Decisions Relating to Residents (Exhibit 5) and procedures adopted by the Washington University/Barnes Jewish Hospital/St. Louis Children's Hospital Graduate Medical Education Consortium.

### **Section 2: Criteria**

House Staff must hold or secure, and maintain, either a permanent or temporary license to practice medicine from the Missouri State Board of Registration for the Healing Arts and meet the requirements of the Department within which they would like to practice.

### **Section 3: Prerogatives**

House Staff may attend to patients under the supervision and direction of physician members of the Medical Staff.

### **Section 4: Supervision**

House Staff, including fellows, shall be supervised by members of the Medical Staff, and such supervision may be evidenced by, among other things, countersignature of House Staff entries and/or a parallel note in the medical record for activities such as:

1. History and physical examination may be reviewed and countersigned by the responsible member of the Medical Staff;
2. Operative notes dictated by House Staff must be reviewed and countersigned by the responsible surgeon member of the Medical Staff, and
3. Discharge summaries dictated or written by House Staff may be reviewed and countersigned, electronically or otherwise, by the responsible member of the Medical Staff.

## **ARTICLE XVIII - MISCELLANEOUS**

### **Section 1: Practice Coverage**

Each attending physician/dentist must assure timely, adequate, professional care for his/her patients in the Hospital by being available, or having available, an alternative physician/dentist with whom prior arrangements have been made and who has at least the equivalent clinical privileges at the Hospital. If a Medical Staff member fails to name an alternate, the appropriate Department Chair, Division Director or his/her designee shall have authority to call any member of the Active Staff to care for the absent physician's patients.

### **Section 2: Emergency Preparedness Plans**

An Emergency Preparedness Manual shall be developed by the Emergency Preparedness Committee. This manual shall contain information and action plans to assist in dealing effectively with emergencies such as earthquakes, fire, severe weather, mass casualties etc.

### **Section 3: Revision of Rules and Regulations**

Rules and Regulations are periodically reviewed and revised, as necessary, to reflect current practices. The revised Rules and Regulations shall be adopted by the Children's Medical Executive Committee and approved by the St. Louis Children's Hospital Board of Trustees.

### **Section 4: Allied Health Professionals**

Policies related to allied health professionals shall be reviewed and endorsed by the Children's Medical Executive Committee.

### **Section 5: Exhibits Attached to Rules and Regulations**

Unless otherwise stated in the Medical Staff Bylaws, the Exhibits referenced in these Rules and Regulations are for information purposes only and may be revised, as necessary, to reflect current practices by the Hospital in conjunction with the Children's Medical Executive Committee.

Adopted by the CMEC: 06/09/93

Adopted by the Medical Staff: 06/14/93

Ratified by the Board of Trustees: 06/28/93

Amended: 09/26/94, 11/25/97, 02/22/00, 09/26/00, 09/25/01, 12/19/01, 06/04/02, 09/09/02, 09/23/03, 06/08/04,  
09/28/04, 11/23/04, 10/25/05, 10/24/06, 06/05/07, 09/16/08, 12/03/08