RULES AND REGULATIONS
MEDICAL AND DENTAL STAFF
OF
CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM
JASPER MEMORIAL HOSPITAL
JASPER, JASPER COUNTY, TEXAS

Inception Date: July 31, 2003
Reviewed & Revised: April, 2016
Reviewed & Revised: July 27, 2017
Reviewed & Revised: September 12, 2019
1. All members of the Medical and Dental Staff of Jasper Memorial Hospital will abide by the Bylaws, Rules and Regulations as herein stated.

ADMISSIONS:

2. Except in emergencies, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission. Admissions are governed by the policies of the Hospital Administration.

3. Clinicians admitting patients shall be responsible for giving such information as may be necessary to assure the protection, not only of the patient, but of other patients and personnel as well.

4. The Hospital shall admit patients suffering from all types of diseases it is prepared and equipped to treat irrespective of race, creed, color, handicap, age, or national origin.

5. Reservations for rooms for patients shall be made in the order of request. No clinician will be permitted to hold beds. During periods involving shortages of hospital beds, priority shall be given to emergency cases.

RECORDS:

6. The attending clinician shall be responsible for the preparation of a medical record for each patient.

7. Each patient must have a history and physical (H&P) performed within twenty-four (24) hours of admission as an inpatient by the attending clinician. When there is a transcription delay, a handwritten note signed by the attending clinician will be placed in the medical record containing pertinent findings (i.e., enough information on the patient record within twenty-four (24) hours of admission for clinicians to manage the patient and guide the plan of care).

7.1 If admitted for less than 48 hours, the admission shall be deemed a "Short Stay Admission" and the attending clinician may use a short stay form containing a chief complaint, present illness, most important points of the past history, a brief physical examination of major systems and emphasizing outstanding abnormalities, outcome of hospitalization, the case disposition and any provisions for follow-up care. The data should be pertinent and relevant and should include sufficient information necessary to provide the care and services required to address the patient’s conditions and needs.

7.2. If admitted for more than 48 hours, the attending clinician shall complete an H&P to include a chief complaint, personal history, family history, history of present illness, physical examination, provisional diagnosis, conclusions, and/or impressions, and course of action planned.
7.3 If a complete history was obtained, and/or a complete physical examination was performed within 30 days prior to admission (such as in the clinician's office or a previous admission), a durable, legible copy may be used in the medical record. However, H&P's done prior to admission will require an addendum/interval note within 24 hours or before surgery. A new H&P will be required if the H&P is 31 days or more. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflection any subsequent changes may be used in the medical record, provided the original information is readily available.

7.4 A discharge summary needs to be completed on all inpatients.

7.4.1. For patients admitted for less than 48 hours, the short stay summary or final progress note can be used as the discharge summary and must include outcome of hospitalization, final diagnosis, surgical procedures if any, condition on discharge and any provisions for follow-up care.

7.4.2. For patients admitted for more than 48 hours, a concise discharge summary needs to be done which includes: the reason for hospitalization, significant findings, procedures performed and care, treatment, and services provided, final diagnosis, the patient's condition at discharge, instructions to the patient and family, as appropriate.

7.5 Before operative and/or invasive procedures, the patient's physical exam and medical history, any diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record. Failure to comply shall cause cancellation of the procedure unless the surgeon states in writing that such a delay would constitute a hazard to the patient.

7.5.1 For the purpose of this section of the Rules & Regulations and the section relating to Surgery, in any emergency, the clinician shall make a brief note, including the preoperative diagnosis, prior to induction of anesthesia and start of surgery. An emergency is defined as any case in which serious harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger.

8. The patient’s medical record includes certain documentation that is entered prior to the patient’s discharge: a signed inpatient admission order and a physician’s “certification” that the admission is medically necessary. The medical record also must include specific reasons why the inpatient admission is medically required and a care plan that includes discharge planning instructions. Inserted 11-4-14 approved by MEC 11-3-14 by Board 1-29-15

9. Patients undergoing surgery shall have an operative report dictated, electronic, or written immediately after surgery, containing the name of the primary surgeon and assistants, name of the procedure performed, findings, technical procedures used, specimens removed, estimated blood loss, and postoperative diagnosis. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.

10. All orders shall be in writing. Only orders from the attending or covering clinician, and clinicians consulted on the case, may be accepted. Verbal orders shall be accepted by a Licensed Nurse, a Licensed Physical Therapist, a Speech Therapist, an Occupational
11. Adequate progress notes should be kept by the attending clinician or credentialed Nurse Practitioner or Physician Assistant. Complete progress notes should be entered into the medical record daily by the attending or designee so that staff involved in the care of the patient have access to the information necessary to manage the patient appropriately.

12. Complete Medical Records. The attending clinician shall be responsible for the timely completion of medical records. All medical records must be completed within thirty (30) days after discharge of the patient.

A Medical Record is ordinarily considered complete when:

(a) its contents reflect the patient’s condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge;
(b) its contents, including any required clinical resume or final progress notes, are assembled and authenticated, dated and timed; and,
(c) all final diagnoses and complications are recorded.

For purposes of this rule, a complete record must contain all clinician reports dictated electronic, and/or written and signed within thirty (30) days after discharge of the patient. Clinician reports include appropriate history and physical, appropriate progress notes, reports of procedures, operative reports if any, and a final clinical resume including discharge diagnosis. Any records not so complete shall be considered incomplete records and shall ensure that a list is published twice monthly, as designated by the Information Management Committee, identifying the clinicians who are automatically suspended for incomplete medical records.

12.1 Automatic Suspension. Automatic suspension means that the affected clinician shall not: admit new patients to the hospital, exercise clinical privileges except with regard to patient in the hospital at the time of suspension; perform consultations; vote or hold office. A second clinician may not assist a suspended clinician to violate this rule without also being subject to automatic suspension or other disciplinary action. A clinician must fulfill emergency room call duty during the period of suspension.

12.2 Recommendation for termination.

12.2.1 Any clinician that does not complete their medical records in 30 days will be placed on the suspension list. If medical records are not completed within the next thirty (30) days, the clinician will receive written notice of then (10) calendar days in which to complete all records.
Any clinician that fails to complete all medical records by the end of the ten-day period (after a total of 70 days), shall be considered to have voluntarily resigned from the medical staff and will be subject to immediate termination of his/her medical staff privileges. Since this is a voluntary resignation from the staff, this is not reportable. Additionally, said physician will not be entitled to a fair hearing and will be required to reapply for medical staff privileges.

Any clinician that completes all medical records within the ten-(10) day period shall not be subject to immediate termination of his/her medical staff privileges. However, if said clinician appears on more than three (3) suspension times during a rolling twelve (12) calendar months, the physician shall be considered to have voluntarily resigned from the medical staff and will be subject to immediate termination of his/her medical staff privileges. Since this is a voluntary resignation from the staff, this is not reportable. Additionally, said physician will not be entitled to a fair hearing and will be required to reapply for medical staff privileges.

13. No medical, dental, or podiatric record shall be filed until it is complete except on order of the Medical Executive Committee. All clinician entries into the medical record must be dated, timed and authenticated by the responsible clinician.

14. The clinicians that wish to use the Central Dictaphone System shall comply with the rules for use of same.

15. **Release of confidential information.**

   15.1 All records are the property of the Hospital and may not be taken from the Hospital unless in accordance with a court order, subpoena, or statute.

   15.2 The Director of Medical Records is custodian of the medical records. The Director of Medical Records shall release information contained in the medical record only in accordance with the rules hereinafter set out.

   15.3 Policies for release of information: Information contained in the medical records shall be released only on the written authority of the patient, his legal representative if he is a minor or mentally incompetent person, the administrator executor of his estate if he is deceased, or in compliance with a court order, subpoena or statute.

   15.4 Attending clinician’s approval not controlling. After the chart is filed, the attending physician has no legal right to determine who shall and shall not see the medical record. He shall be notified that information is being sought.

   15.5 Furnishing information from the medical record. Patients, their attorneys, attending clinicians, and others having a legitimate interest in the medical record of a patient may be provided with a certified copy of the medical record upon presentation of the written authorization of the patient (when someone other than the patient requests the information), or the executor or administrator of the estate in case the patient is deceased, on the payment of the customary hospital charge for such services. Persons presenting such authorization may examine the medical record under the supervision of the Director of Medical Records.

   15.6 Alteration of medical records. After the medical record has been completed and filed, no erasures, deletions, alterations, corrections, additions or other changes shall be made.
15.7 Symbols and abbreviations may be used only when the Medical Staff has approved them. An official record of abbreviations, approved by the Executive Committee, shall be kept on file in the Medical Records Department.

**SURGERY:**

16. An assistant to an operating surgeon may or may not be required at the discretion of the operating surgeon.

17. An individual employed by a clinician to provide assistance during surgery may do so only after: 1) achieving membership on the Specified Professional Personnel Staff pursuant to the procedure set forth in the Bylaws and, 2) being granted appropriate prerogatives to perform such clinical services. Non-physician surgical assistants may perform part of surgical procedures under the direct supervision of the operating surgeon if operating time will thereby be reduced, and the quality of care will not be lessened.

18. Surgeons must be in the operating room and ready to commence operating at the time scheduled, and in no case will the operating room be held longer than fifteen (15) minutes after the scheduled time.

19. The operating surgeon shall identify the patient, before he/she is anesthetized. The CRNA shall record a pre-op note and a post-anesthetic follow-up on the chart.

20. All operations performed shall be fully described by the operating surgeon. All specimen removed at operation shall be sent to the hospital pathologist who shall make such examination as may be considered necessary to arrive at pathological diagnosis and shall issue a report; except that the following categories of specimens, at the clinician’s option, may be exempted from the requirement to be examined by a pathologist:

20.1 specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
20.2 foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;
20.3 specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;
20.4 teeth, provided the number, including the fragments, is recorded in the medical record.
20.5 When radiological studies are done to determine if the count is correct in surgical and/or invasive procedures, the expectation is that the surgeon will personally consult with a radiologist for an interpretation of the film(s).

21. Outpatients undergoing surgical or invasive procedures shall have their pre-operative/preprocedure lab work, diagnostic procedures, appropriate history and physical, operative consent forms, and appropriate documents completed before surgery/procedure.

22. All females past menarche who are to have a general or spinal anesthetic, and who have not had a hysterectomy, shall be required to have a serum pregnancy test before administration of such anesthetic unless specifically overwritten by the attending physician. Patients over 55 years of age need not be subject to the test.
CONSULTATIONS:

23. **Required consultations.** Except in an emergency, consultation with another qualified physician are required in:

   23.1 curettage’s or other procedures by which a known or suspected pregnancy may be interrupted as permitted by the Ethical and Religious Directive for Catholic Health Facilities.
   23.2 cases in which according to the judgement of the clinician consultation would be beneficial.

24. **Consultant.** A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of an individual’s training, experience, and competence.

25. **Essentials of a consultation.** A consultation includes examination of the patient, when necessary, and the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

26. **Responsibility for requesting consultations.** The patient’s clinician is responsible for requesting consultation when indicated. It is the duty of the Hospital through its Executive Committee to make certain that members of the Staff do not fail in the matter of calling consultations as needed. It is the responsibility of the clinician requesting an emergency consultation on an inpatient to contact the consultant directly.

27. A consultant may not become the regular attending clinician of a patient in an illness for which he was called in consultation except with the consent of the clinician who had requested the consultation, or upon the patient’s request that the consultant become the regular attending, and agreement by the consultant.

GENERAL:

28. **Laboratories.** Laboratories shall be provided in the Hospital. All requests and specimens related to clinical pathology or pathologic anatomy to be processed outside of the hospital shall be submitted to the Department of Laboratory and all reports shall be returned to the chart through the Department of Laboratory.

   All anatomic and clinical pathology reports of analyses done outside Jasper Memorial Hospital shall be used at the discretion of the admitting clinician. The Department of Laboratory will review such material upon the clinician’s request. An administrative fee may be charged for this service.

29. Every member of the Staff is expected to be actively interested in securing autopsies. All autopsies shall be performed by a physician delegated this responsibility.

30. All members of the Staff shall cooperate with the Dietitian in the use of the Diet Manuals.

31. Any member of the Staff who shall find fault with a member of the Hospital personnel Staff shall report the deficiency to the supervisor or the department head immediately. If the clinician feels that he/she has not gained satisfaction by reporting this, he/she should then report the deficiency directly to the Administrator, Human Resource Director, or Nursing Service Director.
32. Mass casualty assignments. All physicians not permanently assigned to duties during actual disasters or disaster exercises shall report to the Conference Room for assignment. The Chief of Staff and/or his physician designee and the Administrator of the Hospital will work as a team to coordinate activities and directions. In case of evacuation of patients from one area of the hospital to another, or evacuation from the hospital premises, the Chief of Staff and Administrator will authorize the movement of patients. In their absence, the Chief of Staff physician designee and Administrator on call are next in line of authority.

33. Emergency Room Service.

33.1 The Executive Committee shall be responsible for the organization and function of the Emergency Room.

33.2 Members of the Active Staff including specialists shall be required to take calls in the Emergency Room on a rotating basis for a 24 hour period. The Executive Committee shall have authority to determine who should be excused from taking calls on this service. Staff members who want to be excused from taking calls by reason of health, etc., may apply in writing to the Executive Committee, stating their reasons.

33.3 Responsibilities of the Emergency Room on-call physician include:

a. Admission of patients requiring admission who have no local primary care physician or whose physician has no admitting privileges.

b. Admission of patients of Active or Courtesy Staff member if such member has failed to designate continuous cross-cover or if the designated cross-cover is unavailable. In such situations, the Executive Committee should be informed for corrective action.

33.4 Each clinician on the on-call list shall be responsible for his/her own replacement. Any replacement or change will be communicated to the Emergency Department.

33.5 Any clinician failing to fulfill his/her (*) obligations will be subjected to disciplinary action and possible suspension/loss of clinical privileges. Loss of privileges will be reviewed at reappointment and if recurrent, may result in non-reappointment and/or will be reported to the Texas State Board of Medical Examiners.

*A clinician listed on the on-call schedule or his/her alternate must respond to a call from the Emergency Department and must ensure that medically necessary care is initiated within thirty (30) minutes. If no response from the physician(s) on call within the designated time period, the Chief of Staff or designee will be notified.

33.6 Medical Screening Exam – All individuals who come to the Emergency Department requesting examination or treatment of a medical condition will receive a medical screening examination within the capability of the Emergency Department.

The following individuals are authorized to perform the medical screening exam:
MDs or Dos
Mid-Level Providers – defined as:
Physician Assistants
Nurse Practitioners
Obstetrical RNs

34. Standing delegation orders and protocols must be developed by the attending clinician(s) and approved by the appropriate Medical Staff Committee and forwarded to the Executive Committee for review and approval. Such orders and protocols shall delineate under what set of conditions and circumstances, action should be instituted. All standing orders will be placed in the patients medical record by a person authorized to receive the order and authenticated by the attending clinician within 48 hours. A copy of each standing order and protocol shall be maintained in the Medical Staff Services office. All standing orders and protocols must be reviewed and approved biennially with the clinician’s reappointment package.

35. All drugs, chemicals and biologicals administered to patients shall meet the standards of quality of the United States Pharmacopoeia, National Formulary and be approved by the Federal Drug Administration.

36. It is the policy of the Staff that certain dangerous medication will have an automatic stop order when the number of doses or exact period of administration has not been specified by the clinician. The medications are identified in the policy issued by Pharmacy.

37. Drugs shall be administered only upon the order from a clinician. Only a clinician, pharmacist, Staff registered nurse, licensed vocational nurse and/or professional and vocational nursing students, and radiology technicians, under direct supervision and respiratory therapists within the realm of their assigned duties, can administer medications in the Hospital. Patients may take medications upon physician’s orders.

38. All Staff members must demonstrate evidence of at least the minimum of what is required by the Texas State Board of Medical Examiners which is 24 hours per year and related in part to specialty.

39. Patients undergoing surgery shall not be discharged without the approval of the clinician performing the procedure or his/her designee, unless the clinician performing the procedure has signed off the case.

RULES AND REGULATIONS HISTORY

07/31/03 – Approved by the board.
08/31/2006 – Approved by Medical Staff and Board
February, 2011 – Revised
April 28, 2011 – Approved by the Board
November 3, 2014- Revised and approved by Medical Staff
January, 2015- Approved by Board
April, 2016 – Revised Rule #8 defining who can accept verbal orders.
July, 2017 – Revised Rules #6-12, Records section updated to bring into compliance; revised Rule # 33.6, Medical Screening Exam to remove LVN’s as this is beyond their scope of practice.
September 2019 – Revised rule #11 to allow, within state regulations, Allied Health Professionals, specifically Nurse Practitioners and Physician Assistants, to make progress notes