PART II
RULES AND REGULATIONS
MEDICAL STAFF
OF
CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM
ST. ELIZABETH & ST. MARY
JEFFERSON COUNTY, TEXAS

Inception Date: April, 2005
Biennial Review Date: January, 2007
Reviewed and Revised: July, 2008
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Reviewed and Revised: January, 2013
Reviewed and Revised: July, 2014
Reviewed and Revised: January, 2015
Reviewed and Revised: July, 2015
Reviewed and Revised: October, 2016
Reviewed and Revised: January, 2018
1. All members of the Medical Staff of CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM ST. ELIZABETH & ST. MARY 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 emergency, the provisional diagnosis shall be stated as soon as possible after admission. Admissions are governed by the policies of the Hospital Administration. Only those practitioners granted admitting privileges may admit patients to the hospital. The attending practitioner or his/her designee, also a physician or privileged allied health clinician, shall be responsible for assessing a med/surg and telemetry patient within eighteen (18) hours of admission. The attending practitioner or his/her designee, also a physician or privileged allied health clinician, shall be responsible for assessing the Intensive Care Unit patient within the clinically appropriate time not to exceed 12 hours. The attending practitioner or his/her designee, also a physician or privileged allied health clinician shall be responsible for contacting the transferring physician within 30 minutes and coordinating an appropriate care plan for the patient’s best interest, unless the patient is a direct admit from the physician’s office; a direct admit from the Operating Room; or was seen in the Emergency Department by the attending physician.

3. Staff 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 disease it is prepared and equipped to treat irrespective of race, creed, color, handicap, age, or national origin.

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

RECORDS:

6. Each patient must have a history and physical (H&P) performed and documented within twenty-four (24) hours after admission as an inpatient by the practitioner who has been granted privileges to do so. When there is a transcription delay, a handwritten note signed by the attending Staff Member 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).

6.1. If admitted for less than 48 hours, the admission shall be deemed a “Short Stay Admission” and the practitioner who has been granted privileges to do so may use a short stay summary containing a chief complaint, present illness, salient points of the past history, a brief physical examination of major systems, 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.

6.2. If admitted for more than 48 hours, the practitioner who has been granted privileges to do so 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 impression.

6.3. An H&P should be documented in the medical record before any operative or invasive procedures.

6.3.1. The H&P Assessment is documented in the patient’s medical record before conducting emergency and non-emergency operative and other invasive procedures. For local anesthesia, the minimal assessment will include known allergies, current medications, and vital signs. For conscious sedation, a pertinent H&P examination will be completed according to the guidelines included on the conscious sedation H&P examination form. For general anesthesia, the minimal assessment will be a completed H&P examination. When such H&P examination is not written or on the chart before the time stated for elective surgery, the surgery (including any invasive procedure and cardiac catheterization) will be canceled unless the Staff Member states in writing the procedure is an extreme emergency, life or limb threatening, including but not limited to the following: blunt trauma (severe) to head, neck, chest, or abdomen; burns with suspected respiratory involvement; closed head injuries with altered mental status (loss of consciousness, confusion, etc.); electrical shock; facial (open) fractures; falls (roofs, second stories, etc.); bilateral femur or pelvic fractures; limb amputations, multiple fractures; multiple systems injuries; penetrating trauma to head, neck, chest or abdomen hemodynamically unstable; peripheral vascular injuries (severe); hangings; suspected acute glaucoma (acute pain, blurred vision, nausea); enucleation; alkali eyes, acute visual loss.

6.3.2. If an H&P is not written or on the chart before the time stated for elective procedures, the procedure will be cancelled.

6.4. If a complete history was obtained, and/or a complete physical examination was performed within 30 days prior to admission, such as in the Staff Member’s office, a durable, legible copy may be used in the medical record. H&P’s done prior to admission require an update of any changes to the patient’s condition by a practitioner who has been granted privileges to do so or other qualified individual within 24 hours after admission to be documented in the patient record, either directly on the History and Physical Form, on the progress notes, on the H&P Update form, or dictated as an addendum to the History and Physical. If the H&P is provided by a non-licensed independent practitioner, a practitioner who has been granted privileges to do so will review the H&P, conduct a second assessment to confirm findings, update information and findings as necessary and sign/date the information. The updates should be made available in the patient record within 24 hours after admission or prior surgery. If the patient is going to surgery within the first 24 hours after admission, the update to the patient’s condition and the pre-anesthesia assessment could be accomplished in a combined activity. A new H&P will be required if the H&P was performed 31 days or more prior to admission.

6.5. Outpatients undergoing surgical or invasive procedures shall have their preoperative/preprocedure lab work, diagnostic procedures, appropriate H&P, operative consent forms, and appropriate documents completed before the surgery/procedure.
6.6. No medical, dental, or podiatric records shall be filed until it is complete except on order of the Medical Records Committee. All entries into the medical record must be dated and authenticated by the responsible Staff Member.

6.7. 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.

7. Patients will be discharged only on the order of the attending Staff Member.

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

8. A discharge summary needs to be completed on all patients.

8.1. 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 diagnoses, surgical procedures if any, condition on discharge and any provisions for follow-up care.

8.2. 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, the patient’s condition at discharge, instructions to the patient and family, as appropriate.

9. An operative progress note is required in the medical record immediately after the procedure, when the full operative report or other high risk procedure report cannot be entered into the record immediately after the operation or procedure. Immediately after surgery is defined as “upon completion of surgery, before the patient is transferred to the next level of care.” This is to ensure that pertinent information is available to the next caregiver. In addition, if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care. The operative progress note should include sufficient information that the patient can be cared for until the operative report is placed on the chart.

9.1. Operative reports dictated or written immediately after a procedure should record the name of the primary surgeon and assistants, findings, procedures performed and description of the procedure, estimated blood loss, as indicated, specimens removed, 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.

10. All orders shall be in writing. The only persons authorized to give orders are those practitioners granted such privileges through the Medical Staff credentialing process of CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM ST. ELIZABETH & ST. MARY. All orders must be legible, timed, dated, and authenticated with a signature, initials, or, for orders generated by computerized order entry, an authorized computer-generated signature, entered by the practitioner or practitioners responsible for the care of the patient. All verbal orders should be limited to urgent situations where immediate written or electronic communication is not feasible. The verbal order should be repeated back to the prescribing practitioner. All verbal orders must be reduced to writing, and the person to whom a verbal order is given will sign the order and also
write the name of the practitioner who gave the order. Verbal orders must be authenticated by the practitioner placing the order or another practitioner who is caring for the patient as soon as possible by the earlier of the following: a) the next time the prescribing practitioner provides care to the patient, assesses the patient, or documents information in the patient’s medical record; or b) in any case no later than 48 hours after the order was given. For skilled nursing facility patients, verbal orders must be authenticated the next time the prescribing practitioner assesses the patient or documents information in the patient’s medical record and in any case no later than two weeks after the order was given – and preferably much sooner. The chart is not considered complete until all orders have been authenticated. Verbal orders may be accepted by a Licensed Nurse, a Licensed Physical Therapist, a Speech Therapist, an Occupational Therapist, an Audiologist, a Clinical Dietitian, a Registered Pharmacist, a Perfusionist Technician, a Radiology Technologist, a Radiology Ultrasonographer, a Medical Technologist, a Registered Respiratory Therapist (graduate of AMA approved two year program and registered by the National Board of Respiratory Therapy), a Graduate Respiratory Therapist (graduate of a two year AMA approved respiratory therapy program and completed a one year internship to become eligible for the registry), a Certified Respiratory Therapy Technician who is currently certified by the National Board of Respiratory Therapy, or a graduate Respiratory Therapy Technician who has completed a one year AMA approved certification program and is certification eligible. A Scheduling Coordinator may accept orders for outpatient diagnostic testing not involving medication. A Ward Clerk may accept orders (which may never be orders involving medication) of order types specifically designated by the Executive Committee of the Medical Staff and may do so only if that Ward Clerk has been designated by the Chief Nursing Executive as qualified to accept such orders.

10.1. Restraint: Notwithstanding any mental health rule, a written or verbal order must be given by a physician for each occurrence of the seclusion or restraint of a patient. The order must specify the reason for the restraint. PRN orders are not acceptable. Physicians must evaluate the patient in person prior to continuing the use of restraint beyond each calendar day. Verbal orders should only be limited to urgent situations in which the patient requires restraint for safety reasons and the physician is not able to be present to write the order. In these cases, the physician must still evaluate the patient and authenticate the verbal order within each calendar day that the patient is in restraints.

11. Progress notes should be made by authorized individuals.

11.1. Attending physicians must visit the patient and enter a progress note at least once a day.

11.2. Progress notes should be entered at least every thirty (30) days in the SNF unit.

11.3. All handwritten progress notes need to be authenticated by the individual who wrote the note.

11.4. Dictated progress notes including final progress notes may not be authenticated by one Staff Member on behalf of another Staff Member.

11.5. Progress notes should describe in detail everything of a major character that happens to a patient including pertinent information relative to the course of treatment while in the hospital.

11.6 Progress notes that are written by a physician directed Health Professional Staff member must be countersigned by the responsible supervising physician within 24 hours unless after the Health Professional Staff has satisfactorily completed the six month provisional period and an exemption has been requested by the supervising physician and granted by the Medical Executive Committee.
12. Complete Medical Records: The attending Staff Member shall be responsible for the completion of a medical record within fifteen (15) days after the discharge of the patient. A complete record must contain all Staff Member reports dictated, electronic, and/or written and signed within fifteen (15) days after discharge of the patient. Staff Member reports include: appropriate H&P, appropriate progress notes, reports of procedures, operative reports if any, consults if any, TNM form as applicable, and a final clinical resume including discharge diagnosis as applicable.

12.1. Any record not completed within 21 days shall be considered incomplete and three or more incomplete records will result in automatic suspension of the Staff Member. Automatic suspension means that the affected Staff Member shall not: admit new patients to the hospital, exercise clinical privileges except with regard to patients in the hospital at the time of suspension; perform consultations; perform operations or procedures except those operations/procedures scheduled prior to suspension; vote or hold office. A second Staff Member may not assist a suspended Staff Member to violate this rule without also being subject to automatic suspension or other disciplinary action. A Staff Member must fulfill emergency room call duty during the period of suspension.

Automatic suspension for incomplete charts may be deferred in the following circumstances:
A. If the Staff Member is to be out of town for at least seven (7) working days during the 21 day suspension process, AND if the Health Information Management Department is notified in advance that he/she will be out of town, AND if the Staff Member completes all charts that are 21 days past discharge before leaving town. The Staff Member must complete, within ten (10) days of returning, all charts that are then 21 days past discharge.
B. If the Staff Member is significantly ill or injured. When possible, the Staff Member is expected to so notify the Health Information Management Department.
C. If the chart is not available to the Staff Member and the Health Information Department has been notified in advance that he/she will be arriving to work on completion of his/her charts. The Staff Member will not be suspected for that particular suspension date because of unavailable incomplete/delinquent medical records.

12.2. A list will be published at least twice monthly identifying the Staff Members on automatic suspension.

12.3. If medical records are not completed within the next nine (9) days (after a total of 30 days, the Staff Member will receive written notice he/she must pay $300 and complete the required records. If records are not complete before the date of the Medical Executive Committee meeting, staff member must appear and pay $600 and complete the required records within the next ten (10) calendar days or be considered to have voluntarily resigned from the Medical Staff. Care of the inpatients of a physician placed on voluntary resignation will be the obligation of his/her coverage group. The Staff Member will be required to reapply for staff membership and privileges and pay a $900 fee. Since this is a voluntary resignation from the staff, this is not reportable. Additionally, such Staff Member will not be entitled to a fair hearing and will be required to reapply for Medical Staff privileges.

12.4. If a staff member exceeds the 30 day threshold (2) twice within any six month period Peer Review Committee will review and make recommendations regarding corrective action. If staff member exceeds the 30 days threshold (3) three times within any six month period, practitioner must appear before Medical Executive Committee and pay the
$600 fine. If member is voluntarily resigned by Medical Executive Committee, member must reapply and pay $900.00.

12.5 Personal Appearance Requirement. Any unexcused failure to appear before the Medical Executive Committee when required by this Section 12, shall be considered a voluntary resignation from the medical staff.

13. Release of confidential information. All release of information is controlled by Hospital policies in compliance with State and Federal policies, laws and guidelines including, but not limited to, the Health Insurance Portability and Accounting Act (HIPAA).

13.1 Medical records are the legal property of the Hospital in which they are made. It is the policy of the Hospital to make these records available for inspection by the attending Staff Member. Original medical records are not released unless the hospital is responding appropriately to federal or state laws, court orders, or subpoenas. If the patient dismisses the attending Staff Member and goes to another Staff Member, the records should be made available to the second Staff Member. The Hospital has the right to refuse a request to release the involved records if the request does not comply with applicable policies or procedures, except in court order.

13.2 The Director of Health Information Services is the custodian of the medical records. The Director of Health Information Services shall release information contained in the medical record only in accordance with the rules hereinafter set out.

13.3 The attending Staff Member’s approval is not controlling. After the chart is filed, the attending Staff Member has no legal right to determine who shall and shall not see the medical record.

13.4 Electronic signatures shall be authorized for authenticating medical record data/information produced in the electronic record system. Upon approval, the Staff Member shall be assigned a unique I.D. Code and password for the authentication of patient records. Upon initial use of the I.D. Code, the Staff Member will change his/her I.D. Code. Access to the I.D. Code shall be restricted to the Staff Member only. The Staff Member authorized to use an electronic signature will be required to sign a “Confidentiality Statement” which will be maintained on file in the Administrative offices of CHRISTUS SOUTHEAST TEXAS HEALTH SYSTEM ST. ELIZABETH & ST. MARY. The statement will indicate that the Staff Member must never delegate his/her authorization/I.D. Code to another person and that failure to abide by this policy will result in immediate termination of the use of the I.D. Code.

14. Abbreviations, symbols and acronyms may be used only when they have been approved by the Medical Staff. A standardized list of abbreviations, symbols and acronyms to be used and not to be used will be developed by the Medical Staff.

SURGERY:

15. All females, age 55 or younger, past the age of menarche and who have not had a hysterectomy, must have a pregnancy test ordered within 7 days prior to having general or spinal anesthesia unless specifically over-ridden by the attending Staff Member.

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 Staff Member to provide assistance during surgery may do so only after: 1) achieving membership on the Health Professional Staff; 2) being granted appropriate prerogatives to perform such clinical services. Non-physician surgical assistants may perform parts 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. Before operative and other procedures or the administration of moderate or deep sedation or anesthesia, the site, procedure, and patient are identified. The patient is reevaluated immediately before moderate or deep sedation and before anesthesia induction. The anesthesiologist or other qualified individual shall record a pre-operative note and a post anesthetic follow up on the chart.

20. All operations performed shall be fully described by the operating surgeon. All specimens removed at operation will be sent to the Hospital pathologist who shall make such examination as may be considered necessary to arrive at a 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. therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

20.3. foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;  

20.4. 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;

20.5. placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and

20.6. teeth, provided the number, including the fragments, is recorded in the medical record.

20.7. 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. A surgical procedure shall be performed only on consent of the patient or his/her legal representative. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from the patient or legal representative, these circumstances shall be explained on the chart and the Administrator notified prior to surgery.

CONSULTATIONS:
22. **Required consultations**: Except in emergency, consultations with another qualified clinician are required in:

22.1. All major surgery cases in which the patient is not a good risk, or in which the diagnosis is obscure or curettages or other procedures by which a known or suspected pregnancy may be interrupted as permitted by the Ethical and Religious Directives for Catholic Health Facilities.

22.2. Cases in which according to the judgment of the clinician consultation would be beneficial.

22.3. Consultant. A consultant must be well qualified to give an opinion in the field in which his/her 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. For STAT consults, physician to physician contact is required with appropriate response by the consultant within six (6) hours unless otherwise specified for rapid response programs, i.e. cardiac alert, or unless a shorter time frame is discussed physician to physician and immediate response is requested. Other routine consults should be seen within 24 hours after the consultant is notified. If a consultant feels additional consultants are necessary, the additional consultants should be approved by the attending physician.

22.4 Essentials of a consultation. A consultation, whether written or dictated, shall be labeled as such, and shall include an examination of the patient, when necessary, and a written opinion signed by the consultant. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation. Consultations should be performed and documented in less than 24 hours.

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

22.6. A consultant may not become the regular attending clinician of a patient in an illness for which he/she 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.

22.7. The Section Chairperson shall have the authority to request a consultation of cases in his/her section when indicated. In instances in which the Administrator deems it desirable, the Administrator may request the Chairperson of the respective section to give his/her attention to the case in question.

22.8 Response to In-patient Consultations. All medical staff members that are required to take Emergency Department call are required to respond to in-patient consultation requests. When an in-patient consultation is entered as an order, the consultant that is on ED call that day shall be responsible and obligated to perform the consultation to the level required to properly manage the patient.

23. As primary psychiatric or substance-abuse services are not provided within this Hospital, individuals with these diagnoses will receive a medical screening examination within the capability of the Emergency Department addressing any special needs of the patient. The patient may be referred for outpatient treatment or transferred to an inpatient psychiatry/substance abuse facility according to Hospital policy.
LABORATORY:

24. All tests ordered before or during a patient’s admission to the Hospital shall be properly ordered by the Staff Member and performed by the Hospital laboratory, or a reference laboratory that has ongoing CLIA-88 certification or have “deemed status”, that is, certification by an organization such as CAP (College of American Pathologists) or JCAHO.

25. Every Staff Member shall attempt to secure permission to perform autopsies according to policies and procedures established by the Hospital when the following criteria are met: 1) cause of death unknown; 2) death during treatment with a new therapeutic trial regime; 3) intraoperative or intraprocedural death or death occurring within 48 hours after surgery or an invasive procedure for unexplained cause; 4) death incidental to pregnancy or within seven days following delivery; 5) deaths where the cause is sufficiently obscure to delay completion of the death certificate; 6) deaths in infants/children due to congenital malformations.

No autopsy shall be performed without written consent of the legally responsible party. All autopsies shall be performed by the Hospital pathologist or another qualified pathologist. A written report will be inserted on the patient’s medical record.

EMERGENCY ROOM


26.1. Every member of the Active Medical Staff shall be required to take call in the Emergency Room on a rotating basis; the call schedule rotation will be determined by the applicable Section. There is a two month time period before a new member of the medical staff is inserted into the E.R. Call rotation. Members of Sections/Specialties that do not have enough members to cover the Emergency Room call schedule twenty-four (24) hours/day seven (7) days/week will be on call a minimum of one (1) day out of five (5) days. Where the number of practitioners in a Section/Specialty is five (5) or less, the practitioner shall take a minimum of six (6) days per month. Of those 6 days, 2 days shall be weekend days. For purposes of this requirement, weekend days is defined as Friday, Saturday, or Sunday. A call day is defined 7:00 a.m. to 7:00 a.m.

26.2. Active Staff Members shall establish an office and residence within a distance that will reasonably ensure that he/she is available to render medically necessary care within a reasonable time. Reasonable time is defined as readily available by phone, or in person, if warranted, within thirty (30) minutes. Compliance with this response time is required. However, from time to time there may be extenuating circumstances (i.e. the on call Staff Member attending to another emergency patient) that prevent the on call Staff Member from responding in the thirty (30) minute time frame.

26.3. Each Staff Member on the on call list will be responsible for his/her own replacement.

26.4. Each Section/Specialty at each campus may establish a policy of exemption from Emergency Room call services based on age and at least ten (10) years of service. If application of the exemption results in fewer than three (3) members of a particular Section/Specialty being available to serve on the call roster then the exemption must be considered and approved by the Medical Executive Committee. Not withstanding the above no Staff Member will be required to serve on the on call list after the age of sixty-five (65).
26.5. Sections/specialties on call policies are subject to Medical Executive Committee review and approval.

26.6. All individuals who come to the Emergency Department requesting examination or treatment of a medical condition will receive a medical screening examination (MSE) within the capability and capacity of the Emergency Room. The following individuals are qualified and authorized to perform MSE’s:
   26.6.1. MD’s or DO’s
   26.6.2. Mid-Level Providers: defined as Physician Assistants and Nurse Practitioners
   26.6.3. Obstetrical Nurses and Sexual Assault Nurse Examiners

GENERAL:

27. All Staff Members shall cooperate with the Chief Dietitian in the use of the Master Diet Plan.

28. Any Staff Member finding fault with a Hospital associate shall report the deficiency to the supervisor or the department head immediately. If the Staff Member feels that he/she has not gained satisfaction by reporting this, he/she should then report the deficiency directly to the Department Supervisor, Department Director, Assistant Administrator, or the Administrator. It is the sole responsibility of the Hospital to discipline, reprimand, or terminate Hospital associates.

29. All clinical research performed at the Hospital will be conducted according to rules and requirements developed by the Institutional Review Committee.

30. All studies, patient care evaluations, or assessments of appropriateness of care/treatment proposed by a Staff Member shall receive approval from the appropriate Section or Committee. Prior to data extraction or medical record review, the following characteristics must be approved:
   30.1. The title of the study, evaluation or research.
   30.2. The purpose of the study, evaluation or research.
   30.3. The criteria to be used for data extraction or chart review.
   30.4. The individual or department assigned to perform data extraction or chart review.

Only Staff Members or designated Hospital personnel will be allowed to perform medical record review or data extraction, and they shall adhere to any applicable Hospital rules or requirements.

31. Prescribing Staff Members may, within their discretion at the time of prescribing, approve or disapprove the dispensing of a nonproprietary drug or the dispensing of a different proprietary brand to their patients by the pharmacist. The Staff Member may communicate this option to the pharmacist by writing the words “brand medically necessary” and the name of the drug requested.

32. Health Professional Personnel are to strictly follow their scope of practice. All procedures performed by a Health Professional, regardless of specialty designation, shall be monitored by a licensed independent practitioner competent in the area of specialty of the corresponding Health Professional. Additionally the sponsoring licensed independent practitioner shall be in the room while all invasive procedures are being performed by Health Professional Staff.

AMENDMENT
All proposed amendments to the Rules & Regulations (Part II of the Bylaws), whether originated by the Executive Committee, another standing committee, or a member of the active category of the Staff, must be reviewed and discussed by the Executive Committee prior to an Executive Committee vote. Language may be adopted, amended, or repealed in whole or part by a resolution of the Executive Committee recommended and adopted by the Board. The Executive Committee may correct typographical, spelling, or other obvious errors.
HISTORY OF RULES & REGS OF THE MEDICAL STAFF

2005  Rule 25. Addition of the option for another qualified pathologist other than the hospital pathologist to perform autopsies. Approved by the Medical Executive Committee on 8/25/05 and the CHRISTUS Health SETX Board on 10/26/05.

2006  Rule 12. Addition of language to clarify the process in order to prevent unfair penalties for medical record delinquencies to Medical Staff members. Approved by the Medical Executive Committee on 11/17/05 and the CHRISTUS Health SETX Board on 1/19/06.
Rule 22.4. Addition of identification process for consultation notes. Approved by Medical Executive Committee 1/26/06 and the CHRISTUS Health SETX Board on 4/20/06.
Rule 26.1. Addition of requirement for smaller specialties/sections to fulfill some of its Emergency Room call coverage responsibilities on the weekends. Approved by Medical Executive Committee 2/23/06 and the CHRISTUS Health SETX Board on 4/20/06.

2007  The Rules & Regs were reviewed and recommended for approval with no changes at this time by the Medical Executive Committee at its November 30, 2006 meeting and were approved by the Board of Directors on January 18, 2007.
Rule 6. Revisions made to H&P requirements in accordance with Joint Commission Standards. Revisions allow anesthesia to provide H&P update within 24 hours of admission drafted and approved by JC. Additionally, update information has been added to the bottom of the H&P template for transcribed reports as an option for physicians. Approved by Medical Executive Committee 2/22/07 and the CHRISTUS Health SETX Board of Directors 4/19/07.

2008  Rule 12.4. Addition made to clarify responsibility of inpatient care to members of the call group of a physician voluntarily resigning due to incomplete medical records. Approved by Medical Executive Committee 12/20/07 and the CHRISTUS Health SETX Board of Directors 1/17/08.
Rule 2. Addition to clarify and standardize the expectation for an attending physician to see a patient following admission. Approved by Medical Executive Committee 02/28/08 and the CHRISTUS Health SETX Board of Directors 04/24/08.
Rule 26. Amended to grant an emergency room call exception for the first two months after appointment to the Medical Staff. Approved by Medical Executive Committee 05/29/08 and the CHRISTUS Health SETX Board of Directors 07/24/08.

10.1 Restraint. Revised to meet TJC standards regarding the use of restraints.


2012  Rule 10. Revised as it is no longer acceptable for another practitioner who is responsible for the patient’s care to authenticate the verbal order of the ordering practitioner. Rule 10 revised to allow another practitioner who is caring for the patient to authenticate the verbal order of the ordering practitioner. Rule 2. Revised to clarify who can admit patients to the facility. Rule 11.1; 11.6. To clarify progress notes requirements. Rule 22.3, 22.4. To clarify consultant requirements.

2013  Rule 12. Revised time period for completion of medical records from 30 to 15 days.

2014  Rule 6.7. Added documentation requirements to be entered in the medical record prior to discharge.

2015  Rule 22. Required Consultations. Added Section 22.8 to require physicians that are required to take ED call to respond to in-patient consultation requests. Rule 22.3 revised to require consultant to respond within 6 hours for STAT consult and 24 hours for routine consult.


2018  Rule #2 revised to change the required time frame to see an ICU patient and allows APN’s and PA’s to assess the patient and coordinate the care plan. Rule #11.6 revised allowing exemptions from co-signature requirements for Health Professional Staff once the six month provisional period has been satisfactorily completed.