MEDICAL STAFF RULES AND REGULATIONS

of

CONTINUECARE HOSPITAL OF TYLER

July 1, 2012
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INTRODUCTION

The following Rules and Regulations have been adopted by the Medical Staff of Tyler ContinueCare Hospital at Mother Frances Hospital pursuant to Section 10.1 of the Medical Staff Bylaws in order to implement more specifically the general principles found with the Bylaws. These Rules and Regulations are incorporated into and made a part of the Bylaws, except that they may be amended pursuant to the Section 10.1 Terms defined in the Medical Staff Bylaws shall have the same meaning when used in these Rules and Regulations. If there is a conflict between any provision of the Medical Staff Bylaws and these Rules and Regulations, the provision of the Medical Staff Bylaws shall control and govern.

I. PATIENT'S RIGHTS

The Medical Staff supports the rights of each patient in accordance with the policies and procedures of the Tyler ContinueCARE Hospital at Mother Frances Hospital (the "Hospital") that guide the Hospital's interaction with the care of the patient. The Hospital's policies and procedures describe the mechanisms or processes established to support the following patient rights:

A. Considerate care that respects the patient's personal value and belief systems and treats each patient with dignity.

B. Informed participation in decisions regarding his/her care.

C. Notice concerning the patient's rights while a patient of the hospital.

D. Participation in the consideration of ethical issues that arise in the provision of his/her care.

E. Personal privacy and confidentiality of information.

F. Designation of a representative decision maker in the event that the patient is incapable of understanding a proposed treatment or procedure, or is unable to communicate his/her wishes regarding care.

G. To be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation.

H. The right to ask questions or complain and receive answers.

II. ADMISSION AND DISCHARGE OF THE PATIENT

A. Admission

1. Responsibility – A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital and for the prompt completion of and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Wherever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the order sheet of the medical records.
2. **Length of Stay** – The hospital shall accept patients with an expected length of stay of 14–30 days (aggregate 25 days) who need restorative care and/or have potential for meeting specific goals. Any diagnosis may be appropriate if the patient’s needs meet admission criteria.

3. **General Consent Form at Time of Admission** – A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission.

4. **No Admission Without Provisional Diagnosis Except in Emergencies** – Except in the case of emergency admission, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such treatment shall be recorded as soon as possible. A copy of the Emergency Service record shall accompany the patient to the nursing unit.

**B. Medical Records**

1. **Accuracy and Privacy of the Patient’s Medical Record** – Each attending physician will be responsible for the preparation of a complete, timely and legible medical record for each patient, as required by state and federal laws and regulations. Every member of the Medical Staff shall attend prescribed training regarding the electronic health record (“EHR”) used by Hospital and shall not be issued a login for the EHR until such training is complete. Each Medical Staff Member’s electronic login and password is identical to a written signature and shall be used only by the Medical Staff member and shall not be shared with any other person, including allied health professionals. Every member of the Medical Staff shall comply with the Hospital’s policies related to the privacy and security of medical records.

2. **Content of Patient’s Medical Record** – The content of the medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among healthcare providers. Each medical record shall contain at least the following:

   a. The patient’s name, address, date of birth, and the name of any legally authorized representative.
   b. The date and time of admission and discharge.
   c. The patient’s legal competency status as relevant.
   d. Description of care provided to the patient prior to arrival, if any.
   e. The record and findings of the patient’s assessment.
   f. A medical history and physical examination.
   g. The diagnosis or diagnostic impression.
   h. The reason(s) for admission or treatment.
   i. The goals of treatment and the treatment plan.
   j. Evidence of known advance directives.
   k. Evidence of informed consent for procedures and treatments for which informed consent are required by organizational policy.
   l. Diagnostic and therapeutic orders, if any.
   m. All diagnostic and therapeutic procedures and tests performed and the results.
n. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate.
o. Progress notes made by the medical staff and other authorized individuals.
p. All reassessments and any revisions of the treatment plan.
q. Clinical observations including the patient’s response to care provided.
r. Consultation reports.
s. Documentation of all medication ordered or prescribed for patient including each dose of medication administered and any adverse drug reaction.
t. Anesthesia records
u. Medications dispensed to or prescribed for a patient on discharge.
v. All relevant diagnoses established during the course of care.
w. Any referrals/communications made to external or internal care providers and to community agencies.
x. Conclusions at termination of hospitalization.
y. Discharge summary containing instructions to the patient/family.

3. **Utilization Review Committee** – The Utilization Review Committee of the Medical staff will review a random sample of medical records on a quarterly basis for timely completion and documentation accuracy. Findings from the reviews will be presented to the appropriate constituencies quarterly.

4. **Delinquent Medical Records** – All physicians are responsible for completing their medical records within 30 days of a patient’s discharge. Failure to complete incomplete records within thirty (30) days of discharge may result in the record becoming delinquent and the physician may be suspended of any and all privileges including admitting and consults. Three (3) Notices of Delinquency in one calendar year will result in referral to the Medical Executive Committee for review. If Physician’s Medical Staff privileges are suspended, such privileges shall be automatically reinstated upon the completion of delinquent records. In the event of a crisis situation, temporary privileges may be granted by the Chief Executive Officer or the President of the Medical Staff to the physician whose privileges are suspended.

5. **History and Physical** – A complete history and physical examination shall be recorded within 24 hours after admission and before major diagnostic or therapeutic intervention by a qualified physician. This report should include all pertinent findings resulting from an assessment of all the systems of the body as more fully set forth in Article III Section A. If a complete history and physical has been obtained within thirty (30) days prior to admission, a durable, legible copy of this report may be used in the patient’s hospital medical record, provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission. When so used, the history and physical report must be reviewed, and as needed, updated within 24 hours of admission. All history and physical reports shall be authenticated.
6. **Consultation Reports** – Consultations shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examinations of the patient, and the consultant’s opinion and recommendations. This report shall be made a part of the patient’s record. A limited statement such as “I concur” does not constitute an acceptable report of consultation. When procedures are involved, the consultation note shall, except in emergency situations so verified by the record, be recorded prior to the procedure.

7. **Discharge Summaries** – A discharge summary shall be written or dictated on all medical records of patients hospitalized over 48 hours. The summary concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, the final diagnoses, and any specific instructions given to the patient or family including physical activity, medication, diet, and follow-up. All summaries shall be authenticated by the responsible staff member. If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, the patient shall be requested to sign an “Against Medical Advice” (AMA) form. In the event the patient refuses to sign such a form, a note to this effect along with the signatures of two witnesses will be entered into the AMA form.

8. **Progress Notes**

   a. An admission progress note authenticated by the admitting physician is required within 24 hours of admission and should contain sufficient information to justify admission and guide the nursing personnel and other physicians in caring for the patient until the complete, dictated history and physical is available on the chart.

   b. Progress notes must be written daily by either the attending or consulting physician to provide a chronological record of the patient’s progress. Progress notes shall be written at the time of observation, and shall be dated and signed by the physician at the time the note is entered. The progress notes shall be entered in chronological order.

   c. Progress notes shall be written describing new symptoms arising, changes in the condition of the patient, complicating factors in the course of the disease, indications for continued hospitalization, and reactions to medications or procedures.

   d. Each time a new or revised diagnosis is made, it shall be recorded into the progress notes as soon as possible.

   e. A complete detailed progress note on all special procedures, such as spinal puncture, thoracentesis, biopsies, etc., shall be written immediately after the procedure is completed. Pertinent laboratory and radiological findings and results of any specific examination shall be recorded.

   f. Any employee or individual who treats, counsels, educates, tests, evaluates or ministers to a patient may document in the patients’ medical record as delineated in their job description. Documentation shall be in accordance
with generally accepted professional standards of documentation and as required by the Medical Staff Rules and Regulations, hospital policies and regulatory and accrediting bodies.

g. In the case of the death of a patient, the date, time and circumstances of death must be recorded by the physician or registered nurse pronouncing the death.

9. Incomplete Records – The medical records of those physicians who cannot complete their records due to death, disability or relocation shall be “administratively closed” by updating all progress notes from every professional assigned to the patient and having the CMO or the President of the Medical Staff place a note on the record as to the disposition of the attending physician.

10. Record Retention – All medical records shall be stored either physically or electronically. This length of time for record retention will be in accordance with the Hospital record retention policy and applicable state and/or federal law. The Medical Records Department will provide adequate, ongoing training of personnel relating to retrieval of documents.

11. Symbols and Abbreviations – Symbols and abbreviations shall have only one meaning. Symbols and abbreviations may be used in the body of the medical record and may be used only when they have been approved by the Medical Executive Committee.

12. Final Diagnoses – Final Diagnoses shall be recorded in full or all patients, without the use of symbols or abbreviations, on the discharge summary or face sheet, and shall be dated and signed by the responsible practitioner at the time of discharge.

13. Release of Medical Information – All medical records are the property of the Hospital, and shall be removed from the hospital’s jurisdiction and safekeeping only in accordance with a court order subpoena, or statute. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

14. Physicians in Group Practices – Physicians in group practices or associations may authorize partners/associates to co-sign, start, continue, or terminate the patient’s diagnostic/therapeutic treatment, and make entries in the medical record, so long as those individuals are credentialed members of the medical staff of the Hospital.

C. Emergency Care Services

1. Emergency Patient Transfers – Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility when, in the judgment of the attending practitioner or designee the patient’s condition permits such a transfer. The Hospital’s procedures for patient transfers to other facilities shall be followed.
2. **Emergency Medical Treatment and Active Labor Act (EMTALA)** – In no way shall these Rules and Regulations or any policy of the Medical Staff be in conflict with federal or state requirements and regulations governing the transfer of patients from one hospital to another as stipulated by intent and language of EMTALA.

3. **Emergency Treatment of Visitors and Staff** – Hospital shall maintain an emergency treatment area and all Medical Staff members shall maintain appropriate training to reasonably respond to emergencies of outside visitors and staff.

### III. ASSESSMENTS OF THE PATIENT

#### A. Content and Conditions of History and Physical

A patient admitted for inpatient services has a medical history taken and an appropriate physical examination performed by a physician or who has such privileges. The History and Physical shall include the following:

1. **Physical, Psychological** – There is an initial assessment/screening of each patient’s physical, psychological, and social status to determine the need for care or treatment, the type of care or treatment to be provided, and the need for any further assessment.

2. **Scope/Intensity of Further Assessment** – The scope and intensity of any further assessment are determined by the patient’s diagnosis, treatment setting, patient’s desire for treatment, and patient’s response to any previous treatment.

3. **Nutritional Status** – The need for assessing the patient’s nutritional status is determined through a nutritional assessment from initial screening for determination of moderate or high nutritional risk.

4. **Functional Status** – The patient’s functional status is determined by a functional assessment, which is performed for each patient where appropriate.

5. **Allergies/Drug Idiosyncrasies** – Assessment of the patient’s known allergies or drug idiosyncrasies.

6. **Time Frames** – The initial assessment of each patient admitted is conducted within the first 24 hours of admission as an inpatient or no more than thirty (30) days prior to admission as an inpatient.

#### B. Diagnostic Testing

Diagnostic testing is performed, including laboratory and other invasive and non-invasive diagnostic and imaging procedures, relevant to the determination of the patient’s health care or treatment needs and to the actual care or treatment of the patient.

#### C. Communicable Diseases

Physicians are obligated to report all “Reportable Communicable Diseases” to Public Health authorities. When a communicable disease is suspected or confirmed, isolation precautions should be ordered and maintained.
D. **Suspected Abuse, Neglect or Exploitation of Adults** – Medical Staff members shall screen patients for signs of potential abuse and, if applicable, follow all policies and procedures of Hospital regarding the documentation of findings in the Medical Record and reporting to appropriate authorities consistent with state law and professional licensing regulations.

E. **Consultations**

1. **Qualifications** – Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his or her area of expertise. Opinions requiring medical judgment are written or authenticated only by Medical Staff members and other individuals who have been granted clinical privileges. Unless physician-to-physician contact has been made, or otherwise ordered, the nurse shall notify the consulting physician of the request.

2. **Content** – Consultations shall show evidence of a review of the patient’s record by the consultant, pertinent findings on examination of the patient, and the consultant’s opinion and recommendations. This report shall be made a part of the patient’s record. When operative procedures are involved the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

3. **Conditions** – It is the duty of the Medical Staff, and the Medical Executive Committee, to see that members of the Medical Staff do not fail in the matter of calling consultants as needed, and in all cases, as soon as possible. Judgment as to the serious nature of the illness and questions of doubt as to diagnosis and treatments rests with the practitioner responsible for the care of the patient. Circumstances under which consultations may be sought by the Medical Staff throughout the Hospital include the following:

   a. Cases of serious illness in which the diagnosis is obscure;

   b. Cases in which there is doubt as to the best therapeutic measures to be utilized;

   c. Cases in which, according to the judgment of the practitioner, the patient is not a good medical or surgical risk;

   d. Cases requiring clinical judgment or treatment outside of the attending practitioner’s credentialed specialty/sub-specialty and/or clinical privileges.

   e. The Medical Staff shall give due consideration to the need for psychiatric consultations in patients with the following disorders, which are not all-inclusive:

      i. Suicide attempts
      ii. Acute depression
      iii. Situational depression
      iv. Alcohol or drug dependency
      v. Anxiety disorders
4. **Request Form for Radiology/Pathology** – Consultation request forms for radiology and pathology shall be filled out completely. The attending practitioner is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes by a nurse.

5. **Time Frame** – The Medical Staff Consultant shall see the patient, and the consultation shall be dictated or written, within two (2) days of the ordered consult.

**IV. TREATMENT OF THE PATIENT**

The Hospital shall have at all times a doctor of medicine or doctor of osteopathy available for patient care on duty or on call. Care for each patient shall be under the direction of a doctor of medicine or osteopathy who shall be responsible for any medical or psychiatric problem that is present on admission or develops during hospitalization.

A. **Care or Treatment Decisions** – The information generated through the analysis of assessment data is integrated to identify and prioritize the patient’s needs for care or treatment. These decisions are based on the identified patient needs and on care or treatment priorities. It is the duty of the Medical Staff to inform the patient or the appropriate family member of the patient’s medical condition, including diagnosis/prognosis, and any risk or complications associated with medical or surgical procedures recommended for the patient.

B. **Selecting Appropriate Procedures** – The Medical Staff defines the scope of an appropriate assessment for emergent and non-emergent invasive procedures in accordance with “Assessment of Patients” (see Section III). Through the assessment process, the optimal time for the procedure(s), safe performance of the procedure(s), and provision of a baseline for interpreting findings while monitoring the patient will be established. Assessment provides the information needed to choose the appropriate procedure for the patient.

C. **Use of Special Treatment Procedures** – Special justification must be documented in the patient medical record for the use of special treatment procedures as follows:

1. **Restraints** – Medical Staff members shall follow all Hospital policies and procedures regarding use of restraints. Restraints shall only be used under the following conditions:
   a. Upon written order of a physician or other person lawfully authorized to prescribe care;
   b. The order must specify the duration and circumstances under which the restraints are to be used;
   c. Restraints will only be ordered when less restrictive measures have been found to ineffective to protect the patient and will implemented in the least restrictive manner;
   d. There shall be no standing orders; and
e. There shall be no P.R.N. orders for physical restraints.

Adequate appropriate clinical justification must be documented in the patient medical record for the use of safety restraints under the aforementioned conditions.

2. **Physical Restraints** — The only acceptable form of physical restraints are cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. The requirements for the use of physical restraints are:

a. **Medical/Surgical Restraints** — Medical/Surgical restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures, and shall be applied for no longer than the time required to complete the treatment.

b. **Physical Restraints for Behavior Control** — Physical restraints for behavior control shall only be used subject to the following conditions:

   i. On the signed order of a physician or other person lawfully authorized to prescribe care, except in an emergency which threatens to bring immediate injury to the patient or others. In such an emergency, an order may be received by telephone, and shall be signed within twelve (12) hours. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient’s health record;

   ii. with a written order designed to lead to a less restrictive way of managing, and ultimately to the elimination of behavior for which the restraint is applied;

   iii. that each patient care plan which includes the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method;

   iv. that patients shall be restrained only in an area that is under supervision of staff and shall be afforded protection from other patients who may be in the area;

   v. that physicians or independent licensed practitioners must physically assess the patient within one hour of the initiation of the restraint or seclusion. The original order may be renewed, but must not extend past a 24-hour period; and

   vi. a new order may be issued only after an attending physician sees and assesses the patient.
3. **Chemical Restraints** – When drugs or chemicals are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:
   
a. The specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the patient's health record;
   
b. The plan of care for each patient includes evaluating the effectiveness of the drugs and occurrence of adverse reactions; and
   
c. PRN orders for such drugs shall not be used for behavioral restraints.

4. **Postural Supports** – Postural supports may only be used to improve a patient's mobility and independent functioning, to prevent a patient from falling out of a bed or a chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints. The use of postural supports and the method of application shall be specified in the patient’s care plan and approved in writing by the physician or other person lawfully authorized to provide care. Postural supports shall be applied under the supervision of a licensed nurse and in accordance with the principles of good body alignment and with concern for circulation and allowance for change of position.

D. **Informed Consent**

1. Patients shall have the right to be involved in health care decisions, in collaboration with a physician.

2. To the extent permitted by law, a patient has a right to accept or reject medical care.

3. Patients have the right to access information necessary to enable the patient to make informed treatment decisions. This information shall be presented in a format which the patient can understand; e.g. in their language if they do not speak English, sign language for the deaf, or other appropriate methods.

4. Before obtaining the patient's consent, risks and benefits and any alternative options associated with the planned procedure(s), are discussed with the patient. As appropriate, the patient’s medical record includes documentation of discussion regarding alternative options if they exist, the need for and risks involved with blood transfusions and available alternatives, and any anesthesia options with attendant risks.

5. The physician is responsible, in accordance with Texas statute to obtain the informed consent of their patient prior to any invasive medical or surgical procedure. The process to be followed is set forth in the Informed Consent Policy of Hospital. The invasive medical or surgical procedure shall not occur until an informed consent signed by the patient or healthcare surrogate/proxy, when appropriate, is included in the patient’s medical record. In an emergency and in the absence of an informed consent, the treating physician is responsible to document the patient's diagnosis, the proposed treatment and the medical necessity of the treatment.
6. Patients shall have a right to formulate advance directives such as through the 
appointment of an agent to make decisions on his/her behalf (Medical Power of 
Attorney) or through written instructions about healthcare decisions (Directive to 
Physicians and Out-of-Hospital DNR). In situations where the physician and the 
family or patient disagree on resuscitative measures, the physician, utilizing sound 
medical judgment, will counsel with the family and patient, document the 
conversation thoroughly in the medical record and then will respect the patient’s 
and/or family’s wishes or seek review of the matter by the Ethics Committee of 
Hospital.

E. Orders

1. Treatment Orders – All orders for treatment must be in writing. The practitioner’s 
orders must be written clearly and completely and dated and signed in the EHR.

2. Order Sets – Practitioners may formulate standard order sets which may be 
implemented in the EHR and become part of the medical record. All order sets must 
be authenticated and signed by the practitioner.

3. Verbal Orders

a. Due to the availability of the EHR from remote locations, the use of 
telephonic or verbal order should be used rarely and only where 
circumstances are warranted.

b. Practitioners giving verbal orders shall permit the receiver of the order time 
to write the complete order, read it back in its entirety to the practitioner, and 
receive confirmation of accuracy from the practitioner.

c. All verbal orders shall be authenticated as soon as possible, but not less than 
48 hours following the order.

d. All previous orders are cancelled when patients enter a different level of care.

e. The attending practitioner shall countersign all orders, the history and 
physical examination and pre-operative notes when they have been recorded 
by physician’s assistant or nurse practitioner.

f. Orders for inpatient services will only be accepted from Medical Doctors, 
Doctors of Osteopathy, Doctors of Podiatry, and Doctors of Dental Services, 
and approved and credentialed AHPs.

g. Orders which are not written with sufficient clarity will not be carried out 
until verified and understood by the care giver.
4. **Professionals Who May Receive Verbal Orders**
   
a. Non-medication orders may be received by:
   
i. Licensed nurses
   ii. Pharmacists
   iii. Certified respiratory therapists
   iv. Registered respiratory therapists
   v. Registered physical therapist
   vi. Clinical dietitians
   vii. Occupational therapists
   viii. Social workers
   ix. Speech language pathologists
   
b. A signed order for tests and procedures is required. The scheduling of a test or procedure is not considered an order.

5. **Medication Orders**
   
a. Medication orders may be accepted and transcribed by:
   
i. Licensed nurses
   ii. Pharmacists
   
b. Verbal orders shall not be taken for chemotherapeutic agents.

6. **Transfusion Services Orders** – Must be received in writing by registered or licensed nursing personnel.

7. **Automatic Stop Order**
   
a. There shall be an automatic stop order on all narcotics, antibiotics, steroids, anticoagulants, barbiturates, and tranquilizers consistent with Hospital policy unless the exact number of doses or treatment have been clearly specified by the physician.
   
b. There shall be an automatic release after 48 hours for blood ordered on a standby basis unless the attending physician requests an extension of time.

V. **ALLIED HEALTH PROFESSIONALS**

A. **Definition**

An Allied Health Professional ("AHP") is an individual, other than a licensed M.D., D.O., Dentist, or Podiatrist, who exercises clinical judgment in the area of their professional competency, who is qualified to provide patient care services within the scope of his/her license, registration and/or certification, and as delineated in his/her respective credentialing criteria.
1. **Independent AHP**

Independent AHPs consist of licensed professionals who may provide patient care services, within the scope of his/her license and consistent with the privileges granted. Independent AHP shall include but not be limited to Licensed Psychologists, Physician Assistants, Certified Registered Nurse Anesthetists, and Licensed Nurse Practitioner. An independent AHP shall:

a. Exercise independent judgment within the scope of his/her license, provided that a physician member of the Medical Staff shall have the ultimate responsibility for the patient’s medical care;

b. Participate directly in the management and care of patients under the general supervision or direction of a Medical Staff member, with the exception of Psychologists who may practice without supervision or direction of a Medical Staff Member;

c. Record reports and progress notes on the patient records; and

d. Not admit or discharge patients.

2. **Dependent AHP**

Dependent AHPs consist of licensed professionals who do not practice independently, but who practice their profession within the scope of their license at the direction of a sponsoring physician. Dependent AHPs may include but not be limited to Physician Assistants, Advanced Registered Nurse Practitioners, and R.N. First Assistants.

B. **Appointment/Reappointment/Clinical Privileges of AHPs**

1. **Privileges**

Practice at the Hospital as an AHP is a privilege which shall be extended only to those professionally competent licensed AHPs who continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws of the Hospital. Whenever the term “privileges” is used in this Section, it shall be defined as and be deemed permission to perform those specific functions and activities granted, and shall not encompass those privileges as granted to physician members of the Medical Staff.

2. **Application and Appointment**

AHPs shall be subject to appointment and reappointment processes set forth in Section 5.9-7 of the Medical Staff Bylaws.
F. **Hospital-Employed AHPs**

AHPs who are employed by the Hospital are subject to the requirements and regulations of their employment and are not subject to the Medical Staff Bylaws and Rules and Regulations. Hospital-employed AHPs undergo an equivalent review process at the time of application for employment and are regularly reviewed in the Hospital’s performance appraisal process.

**VI. MISCELLANEOUS**

A. **Pronouncement of Death** – In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his or her designee within a reasonable time. Policies with respect to the release of dead bodies shall conform to local law. The Medical Staff will abide by federal and state regulations regarding organ/tissue donations.

B. **Autopsy** – Each member of the Medical Staff should make an attempt to secure autopsies in all cases of unusual deaths and of medical, legal, and educational interests, or in those cases where an autopsy is required by law; i.e., medical examiner or coroner case (“Coroner’s Cases”). No autopsy shall be performed without consent. Generally, autopsies shall be performed by the hospital pathologist or a qualified pathologist approved by the hospital pathologist, except in Coroner’s Cases, where the medical examiner or coroner or their respective deputy and appropriate law enforcement agency shall be notified, and which shall report to the scene within a reasonable period of time.

1. **Requesting an Autopsy** – The following are indications for autopsies performed at the request of a medical staff member:

   a. Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same.

   b. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.

   c. Deaths in which the patient sustained or apparently sustained an injury while hospitalized that may have contributed to the patient’s death.

   d. Deaths at any age in which organs are donated and it is believed that an autopsy would disclose a known or suspected illness which may have a bearing on survivors or recipients of the transplant organs.

   e. Deaths known or suspected to have resulted from environmental or occupational hazards.

If any of the above indications exist and an autopsy cannot be performed, the reason should be documented in the medical record.
2. **Documentation of Request** – When attempting to secure permission for autopsies, the physician shall document the following information in the patient’s medical record:

   a. Party requesting the autopsy
   
   b. Response received to request for autopsy
   
   c. Other pertinent information deemed applicable

   Said documentation shall be recorded in the Physicians’ Orders or Progress Notes of the patient’s medical record.

3. **Consent** – No autopsies shall be performed without the consent of the next of kin or the legally authorized agent. Hospital personnel shall notify the attending physician of any impending autopsy.

4. **Transportation of the Body** – All autopsies shall be performed by the Hospital pathologist or by a physician to whom this responsibility has been properly designated. The body shall be transported to the designated hospital as requested by the next of kin or the legally authorized agent.

5. **Reporting to the Coroner or Medical Examiner** – The Hospital shall report the following deaths to the coroner or medical examiner:

   a. When the death of a human being appears to be caused by homicide or violence;
   
   b. When the death of a human being appears to be the result of suicide;
   
   c. When the death of a human being appears to be the result of the presence of drugs or poisons in the body;
   
   d. When the death of a human being occurs under the age of forty (40) and there is no past medical history to explain the death;
   
   e. When the body is to be cremated and there is no past medical history to explain the death;
   
   f. When the death of a human being is sudden and unexplained.

   Autopsy reports shall be filed in the patient’s record upon receipt.

C. **Policies and Procedures of the Medical Staff or Hospital** – Policies and procedures referred to previously and elsewhere in these Rules and Regulations are to be found in the Policy and Procedure Manuals of the Hospital or the Medical Staff. Policies and procedures governing use of various facilities of the Hospital, when determined and published by authorized committees or the appropriate departments of the Medical Staff and approved by its Executive Committee and the Governing Board from time to time, shall be adhered to by all members of the Medical Staff. Members of the Medical Staff are responsible for remaining abreast of current directives.
D. **Protocol For Reporting Practitioner-Patient Care Problems** – The procedure set forth below should be followed by all Hospital personnel, as well as Medical Staff and allied health professional staff when there is a concern that requires Medical Staff attention:

1. The Hospital employee should first check with the attending physician.

2. If the attending physician is not available, or is unresponsive, the Hospital employee should contact the Nursing Supervisor, who in turn should contact the Director of Nursing, when applicable, and then again, the attending physician.

3. If the problem is not solved at this point, then the President of the Medical Staff should be contacted by the appropriate “administrative” employee.

E. **Disaster Plan** – Hospital maintains a disaster / emergency preparedness plan for the care of patients in the event of an internal or external disaster which interrupts the environment of care. The Medical Staff shall be familiar with and know to support the Hospital’s plan in the event of a disaster or emergency.

VII. **ADOPTION AND SIGNATURES**

These Rules and Regulations, which are a part of the Medical Staff Bylaws of ContinueCare Hospital of Tyler, are adopted and made effective **June 27**, 2012, superseding and replacing any and all previous Medical Staff Rules and Regulations.

**APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE:**

[Signature]
Medical Staff President

[Signature]
Date

**APPROVED BY THE GOVERNING BOARD:**

[Signature]
Hospital Governing Board Chairman

[Signature]
Date