CHRISTUS MOTHER FRANCES Hospital Winnsboro

RULES AND REGULATIONS OF THE MEDICAL STAFF

MEDICAL EXECUTIVE COMMITTEE APPROVAL: January 16, 2020

GOVERNING BOARD APPROVAL: January 28, 2020

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RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE

1. The Hospital shall accept patients for care and treatment.

2. A patient may only be admitted to the Hospital as an Inpatient or placed in Observation by a member of the Active or Courtesy Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.

3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion 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. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

4. The admitting physician shall be responsible for admitting orders. For patients that are admitted through the Emergency Department, the ED physician on duty may write admitting orders in conjunction with the attending physician.

5. Except in an emergency, 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 statement shall be recorded as soon as possible.

6. Emergency Admissions
   Any patient admitted through Emergency Room must be seen within 24 hours by the attending physician.

7. Patient Discharge
   Patients shall be discharged upon a written order the attending physician or their AHC after appropriate collaboration has occurred and is documented in the medical record.

   a. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

8. Patient Transfers
   No patient will be transferred without such transfer being approved by the responsible practitioner.

   A patient shall not be transferred to another medical care facility unless there is an accepting physician at the other medical facility and prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

9. Patient Death
   In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. Suicides, known or suspected and accidental deaths, shall be reported to the local law enforcement authorities. Policies with respect to release of dead bodies shall conform to local law.

   In the event of a hospital death, the deceased shall be pronounced dead within a

reasonable time by the attending practitioner or his designee or by a registered nurse acting within the guidelines of the nursing policy pertaining thereto. Policies with respect to release of the deceased shall conform to local law. The attending physician will be responsible for signing death certificates.

10. Autopsy
    It shall be the duty of all staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. An exception to this rule will be those in which the Justice of the Peace will determine disposition of body for autopsy. Provisional anatomic diagnosis shall be recorded on the medical record within a reasonable time. The complete autopsy report should be made a part of the record. Physicians should document request for autopsy or contraindications.

B. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

2. History and Physical Examination
   A complete history and physical (H&P) exam has the following components: history, physical examination, assessment and treatment plan as indicated:

   a. History includes:
      - Presenting diagnosis/condition (chief complaint/reason for the visit)
      - Description of symptoms
      - Current medications, biological, nutraceuticals will no longer be required in the H&P but can be found in the EMR under Medication Reconciliation.
      - Any drug allergies
      - Significant past medical & surgical history
      - Review of systems
      - Psychosocial status
      - Nutritional evaluation (if GI, pediatrics, or elderly)

      For surgery or invasive procedure requiring moderate sedation or anesthesia:
      - Indications
      - Proposed procedures
      - ASA Classification: regardless of whether Anesthesiology is providing care
      - Immunizations (pediatric patients only)

      Pre-operative history and physicals should be dictated 24 hours prior to the time of scheduled surgeries or procedures requiring anesthesia services in order to allow reasonable transcription time. In cases where a complete history and physical is not present in the medical record, the clinical supervisor will request the admitting physician, or if unavailable, the surgeon to record a pertinent handwritten

history and physical in the medical record prior to the induction of anesthesia. A history and physical must be performed within thirty (30) days of admission. If a history and physical is performed within 30 days of admission and is greater than 24 hours old, a History and Physical Addendum Note or update with new or unchanged assessed findings will be required. If history and physical is older than thirty (30) days, a new examination and history and physical is required.

All non-MD and non-DO staff members must have a primary care H&P for patients. The primary care does not have to be a member of the medical staff, but a qualified medical provider.

b. Physical examination (should include as appropriate an examination of body areas/organ systems):

- Vital Signs
- Cardiovascular system
- Respiratory system
- Neurological system
- Gastrointestinal system
- Eye
- Ear, nose and throat (ENT)
- Genitourinary system
- Musculoskeletal
- Skin
- Psychiatric
- Hematologic/lymphatic/immunologic

c. Assessment

d. Treatment Plan

If the history and physical exam is completed by a designee of the admitting physician, the admitting physician must review and validate the content with a signature within 24 hours. Entries must be signed, dated and timed.

3. History and Physical for Outpatient Services
The history and physical will minimally consist of a chief complaint, brief history, including current medications and allergies and a system-specific physical to include a respiratory and cardiac examination, diagnosis/problem list with initial plan of care.

4. Progress Note
A hospitalized patient must be seen by the Attending Physician or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient on the day of visit in sufficient detail to allow formulation of a reasonable picture of the patient's clinical stats at the time of observation.

a. For patients in Swing Bed care, pertinent progress notes shall be recorded at a minimum of once per week.

5. Operative Notes
Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care.

The brief operative or procedure note must include the following elements:

- The name of the primary surgeon and assistants
- Postoperative diagnosis
- Procedure performed
- Estimated blood loss or indicate "note", if there was no blood loss
- Complications or indicate "note", if there were no complications.

A full operative or procedure report must be documented or dictated for transcription within 24 hours after surgery. The report should contain:

- Preop diagnosis
- Postop diagnosis
- Operations performed
- Principal surgeon, assistant surgeons, type of anesthesia administered
- Intraoperative findings
- Description of the procedures performed
- Intraoperative complications, if any
- Specimens removed
- Estimated blood loss
- Type of anesthesia or sedation
- Date and time of procedure

The operative report shall be made a part of the current medical record and signed as soon as practicable. If the operative report is not dictated within 24 hours, the physician will be considered delinquent and sent a warning letter.

6. Consultations
Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, 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, be verified on the record, be recorded prior to the operation. Consultations are to be completed within twenty-four (24) hours of the time of request.

7. Legibility, Date, Time, Authentication
   All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated in either written or electronic form by the author.

8. No Unapproved Symbols or Abbreviations
   Designated unapproved symbols and abbreviations should not be used. An official record of unapproved abbreviations should be kept on file in the record room. The use of Unacceptable/Do Not Use Dangerous Abbreviations shall result in clarification with the practitioner in the interest of patient safety. The use of Unacceptable/Do Not Use Abbreviations applies to all orders and all medication-related documents.

9. Final Diagnosis
   Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of the patient's discharge. This will be deemed equally as important as the actual discharge order.

10. Discharge Summary
    A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over 48 hours. The discharge summary contains the following information:

    a. Reason for hospitalization.
    b. Significant findings.
    c. Procedures performed, and treatment rendered.
    d. Patient's condition at discharge.
    e. Any instructions to the patient/family or significant other.
    f. Final diagnosis.

    When individual patients are seen for minor problems or interventions, and stay less than two days, a final progress note may be substituted for the discharge summary. A final progress note includes the final diagnoses, sufficient information to justify the diagnosis and warrant the treatment, and disposition of the patient at discharge. The discharge summary is the responsibility of the attending physician. In the event of patient death, a full discharge summary shall be completed.

11. Death Summary
    The Death Summary is entered in the electronic health record or dictated for transcription and the content of the death summary should be consistent with the rest of the record and include:

    a. Admitting date and reason for hospitalization
    b. Date of Death
    c. Final Diagnoses
    d. Succinct summary of significant findings, treatment provided and patient outcome
    e. Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
    f. Documentation of all procedures performed during current hospitalization and complications (if any)

12. Copy Forward
    Clinical information should never be "cut and pasted" from different patient charts. When specific elements of the same patient's prior notes do not change from one encounter to the next during the same clinical episode, those elements may be copied forward or preferably acknowledged by reference rather than re-entered. Examples of information that is less controversially copied or carried forward by reference – when truly needed to communicate decision-making for the active encounter – include elements of the previously recorded:

    a. Past Medical/Surgical/Obstetric/Psychiatric History
    b. Family History
    c. Social History
    d. Past relevant reports (labs, imaging, pathology, etc.) with dates
    e. Some unique circumstances where other aspects of the patient's history might be copied, such as when the patient is unable to provide this information and the original source (typically a family member or guardian) is no longer accessible.

    A patient note must always reflect the status of the patient at the time of note creation. It is inappropriate to Copy Forward elements of the History of Present Illness, Physical Examination, and Assessment and Plan without modifying these elements to reflect current status of the information, including specific notation of Assessment and Plan that pertains to the current condition of the patient.

    In addition, the History of Present Illness, Physical Examination, and Assessment and Plan should reflect the work product of the final author and not be carried forward from other providers' notes except in the unique circumstances noted above, and then only with attribution to the original author.

13. Informed Consent
    It shall be the responsibility of the physician to document that he has provided the patient with the risks, benefits, and alternatives in medical, surgical and anesthesia procedures requiring informed consent. This entry must also be dated and timed. This may be documented in the Physician Progress Notes, in the Operative Report or on the Physician Pre-Sedation Assessment History & Physical or by signing the Anesthesia, Surgical & Medical Informed Consent signed by the patient.

14. Record Safekeeping
    Original hard copy records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or state law. 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 of the Medical Staff.

    Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the medical staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attend such patients in the hospital.

All medical records shall be maintained in accordance with the Record Retention and Destruction Policy of the respective facility.

All orders (except verbal orders as set forth below) must be dated, timed and authenticated by the next time the prescriber or another practitioner who is responsible for the care of the patient and has been credentialed by the Medical Staff and granted privileges which are consistent with the written orders, provides care to the patient, assesses the patient, or documents information in the patient's medical record.

15. Verbal Orders
    All verbal orders must be dated, timed and authenticated within ninety-six (96) hours by the prescriber or another practitioner who is responsible for the care of the patient.

16. Completed Medical Record
    Medical records shall be completed within fourteen (14) calendar days following discharge.

    a. In order to manage the record completion process, The Health Information Management Department will send a notification letter once monthly advising practitioners of the need to complete all delinquent records within 14 days of receipt of the notification.
    b. Failure to complete records within the designated time frame will result in temporary suspension of admitting and/or clinical privileges until such time as all delinquent records are completed.
    c. Suspension letter informs the physician in writing that the attached summary medical records report must be completed by a specific date and time; and if the medical records remain incomplete that his/her admitting and/or clinical privileges shall be denied until all delinquent medical records have been completed. This is inclusive of physician signatures / electronic signatures on transcription.
    d. Suspension letters for failure to complete medical records will be included in the provider's credentialing file and tracked in the OPPE database.
    e. Physicians may access the electronic medical record system to obtain detailed information regarding their incomplete and delinquent medical records at any time.
    f. When a private patient of the suspended physician desires admission to this Hospital, the patient shall name another physician of his choice.
    g. Three such suspensions of admitting and clinical privileges within any 12-month period may be sufficient cause for referral to the Medical Executive Committee for action.
    h. Medical Executive Committee may take such action as necessary up to and including recommendation of termination, additional CMEs, and other appropriate actions against any physician with three suspensions within any 12-month period.

    In the event the incapacitation of a practitioner, for whatever reason, will preclude the timely completion of outstanding medical records, the Chief of Staff is empowered to appoint an active medical staff member or members to complete said records. Failure to complete such records on the part of the appointed practitioner within 5 days will subject him to the same sanctions of the Medical Staff Bylaws, Article IX, as though the records were originally his own. A medical record shall not be

permanently filed until it is completed by the responsible practitioner or is ordered filed by the MEC.

C. GENERAL CONDUCT OF CARE

1. Consent for Treatment
   Consent forms will be obtained for all invasive procedures in accordance with the Texas Medical Disclosure Panel guidelines. This specifically requires that the patient, or an individual who may legally consent for the patient, must understand the nature of the procedure or treatment, the medically acceptable alternative procedures or treatments, the substantial medical risks and hazards inherent in the proposed treatment and the significant medical risks associated with refusal. It shall be the responsibility of the practitioner performing the procedure to provide the patient or representative with this information.

2. The Medical Staff shall recognize the rights of patients to self-determination including:

   a. The right to accept or refuse medical or surgical treatment;
   b. The 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 the physician written instructions about health care (Directive to Physicians which includes the Out-of-Hospital DNR).

3. In situations wherein the physician and 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 will then respect the patient and/or family's wishes for that care. (See Patient Self-Determination Policy)

   a. If an Attending Physician disagrees with and refuses to honor a treatment decision chosen by a patient or the patient's representative, the conflict shall be reviewed by the Ethics Committee. The patient shall be given life-sustaining treatment at a minimum through the review process. The Attending Physician shall not be a member of that committee.
   b. If the physician, patient or the patient's representative responsible for the healthcare decisions of the patient is requesting life-sustaining treatment that the Ethics Committee decides is inappropriate, the patient shall be given life-sustaining treatment pending transfer. The physician and the facility will work together to transfer the patient to a willing provider.
   c. If within ten (10) days a willing provider cannot be found life-sustaining treatment may be stopped unless a court of law has granted an extension of time within which life-sustaining treatment must be given. (See Ethics Committee Policy).

4. Physician Orders
   All orders for treatment shall be in writing or electronically submitted and must comply with current Hospital policy for telephone orders.

   The practitioner's orders, written or electronic, must be clear, legible, and dated and timed. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.

5. Consultation
   Consultation is encouraged in the following situations:

   a. When the patient is not a good risk for operation or treatment;
   b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
   c. Where there is doubt as to the choice of therapeutic measures to be utilized;
   d. In unusually complicated situations where specific skills of other practitioners may be needed;
   e. In instances in which the patient exhibits severe psychiatric symptoms; and
   f. When requested by the patient or his family

   The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. All consultations should be made physician to physician or with knowledge and consent of the sponsoring physician.

6. Podiatric care

   a. Outpatients
      Podiatric providers shall perform and dictate a focused history and physical examination for ASA Class I or II outpatient surgeries. Patients with an ASA Class III or higher will require a history and physical examination to be performed by a qualified licensed individual, acting within their scope of practice under state law or regulation, who is not required to be a member of the medical staff. The history and physical examination must be completed within 30 days of the scheduled procedure or prior to a procedure requiring anesthesia services. The podiatrist is required to provide an update to the history and physical examination to include any changes and/or specialty examination. If any medical or psychiatric problem is present at the time of service or develops during the service that is outside the scope of practice of the podiatric provider, a physician member of the medical staff must be consulted.
   b. Inpatients
      A patient admitted for podiatric care is the dual responsibility involving the podiatrist and a physician member of the medical staff or Inpatient hospitalist. Podiatric Inpatients require a history and physical examination to be performed by a qualified licensed individual, acting within their scope of practice under state law or regulation, who is a member of the medical staff and is responsible for the admission. The history and physical examination must be completed within 24 hours of admission. Securing the appropriate medical consultations and seeing that a physician follows the course of a patient while in the hospital is the responsibility of the admitting podiatrist.

7. In the interest of patient safety critical lab values called to the physician shall be read back so as to confirm accurate transmittal to the physician.

8. Medication reconciliation is a prescribing activity and as such the execution of medication reconciliation is seen as a responsibility of the physician. Medication reconciliation shall be completed on admission, at the time of patient transfer to a different level of care and at the time of the patient’s discharge

9. All patients admitted to the Hospital or placed in observation will be evaluated by a member of the Active or Courtesy Medical Staff. Allied Health Practitioners may not independently admit patients.

10. Restraints and Seclusion
    The use of restraints shall be limited to only those situations in which alternatives have failed or there is imminent danger to self or others. Any use of restraints requires appropriate clinical justification. A written time limited order is necessary from the physician for each use of restraints. PRN orders shall not be accepted.

11. Organ Procurement
    Organ procurement shall be handled as required by and in a manner consistent with the Hospital's Organ and Tissue Donor policy and relevant state and federal laws. Practitioners from outside transplant centers, tissue banks or organ procurement centers who come to the hospital for the purpose of harvesting organs for transplant, therapy or research shall be excluded from any requirement for membership in the medical staff.