Claiborne County Hospital

Medical Staff Rules & Regulations

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ARTICLE I

ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the hospital.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instruction, and for transmitting report of the condition of the patient. Whenever these responsibilities are transferred to another staff member, and the staff member is on call, the charge nurse will be notified of absence and coverage during that time.

3. 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.

4. In an emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, first contact the nursing service to ascertain whether there is an available bed.

5. Practitioners admitting emergency cases shall be prepared to justify to the medical staff and the administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission.

6. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner to attend to him. Where no such selection is made, or where the practitioner does not accept the patient, a member of the medical staff will be assigned to the patient, on a rotation basis. The Chief of Staff shall provide a schedule for such assignments.

7. Any patient with known suicidal intent should be offered psychiatric care, and the record must contain clear evidence that such referral was offered, whether or not the patient and family elect to utilize the offer. The attending physician shall cooperate in arranging discharge or transfer to another facility. If immediate discharge or transfer cannot be arranged, and the attending physician determines that a problem exists, the hospital will be responsible to ensure that the patient is supervised at all times by an appropriate attendant, upon physician order. If necessary, police authorities will be summoned to ensure protection of all concerned.

8. Each member of the Active Medical Staff with Admitting Privileges must reside within thirty (30) minutes of the facility. An on-call practitioner who will be out

of town while on call must have Active Medical Staff coverage and notify the charge nurse.

9. The Medical Staff shall define the categories of medical conditions and criteria to be specifically used in order to implement patient admission priorities and the proper review thereof.

10. Patient transfers:

    Transfers priorities shall be as follows:
    a. Emergency room to appropriate bed.
    b. From temporary placement in an inappropriate geographic area to the appropriate area for that patient.

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

11. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients may be a source of danger from any cause whatever.

12. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as approved by the Medical Staff. This documentation must contain:

    a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the diagnosis is not sufficient.
    b. Plans for post-hospital care.

    Upon request of the Medical Staff, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized thirty days or longer, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within twenty-four hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Staff for action. Any patient remaining in the hospital over two months must have the stay approved by the Medical Staff and by the Chief Executive Officer.

13. Patients shall be discharged only upon order of the attending physician. 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.

14. In the event of a hospital death, the following "Patient Expiration Procedure" shall be instituted:

SUBJECT: Patient Expiratory Procedure

I. Impending Expiration

1. The Registered Nurse will make the following written observation in the medical record:

a. Cessation of heart beat
b. No pulse
c. No blood pressure
d. Dilated pupils
e. Other

He or she will then,

2. Notify the attending physician.

3. The attending physician will instruct the nurse as to the appropriate measures to follow which may be:

a. Notify family of patients' death.
b. The attending physician may desire to come; especially if the nurse encounters difficulty with family members.
c. Release patient to the mortuary of family's choice.
d. Autopsies may be requested by family or physician.
e. ER physician to assess and pronounce patient.

II. All notations regarding observations and actions must be written in the medical record.

III. Complete appropriate forms.

IV. Anticipate needs of patient and family.

15. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility.

Provisional anatomic diagnoses shall be recorded on the medical record within three days and the complete protocol should be made a part of the record within ninety days.
Criteria to be considered by the Medical Staff for autopsy include but are not limited to the following:

- Unanticipated death.
- Intraoperative or Intraprocedural death.
- Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
- Death where the cause is sufficiently obscure to delay completion of the death certificate.
- Deaths in which the patient sustained or apparently sustained an injury while hospitalized.

17. OCHA STATEMENT

Credentialing, Organized Healthcare Arrangement:

As a condition of appointment or reappointment, each applicant shall, effective as of the date of appointment and so long as such applicant shall remain a member of the Medical Staff:

(a) be a participant in an "organized health care arrangement" with Hospital ("hospital OHCA') as defined in 45 C.F.R. section 164.501, in order to use and disclose protected health information for their joint health care activities in treating Hospital patients; and

(b) by reason of participating in the Hospital OHCA, be a participant in a system-wide OHCA ("System OHCA") with all Covenant Health hospitals and facilities and the members of each such hospital or facility's OHCA, in order to permit use and disclosure of protected health information as an organized system of health care.

Participants in each OHCA shall use a single joint privacy notice, and each Covenant hospital of facility, including Hospital, shall be responsible for obtaining the written acknowledgement of receipt of such notice. Each participant in the Hospital OHCA and System OHCA shall be solely responsible and liable for its/his/her own acts and omissions, and neither OHCA shall be construed as a joint venture, partnership or agency and joint and several liability is not intended.

18. Appointment, Reappointment Certification Requirements

Current ACLS, ATLS and PALS certification is required for emergency room physicians. Current ACLS and PALS certification is required for emergency Room physician extenders; Current ACLS certification is required for hospitalists.

Board Certification: with the exclusion of Medical Staff privileged prior to 2010, all Medical Staff members must be Board Certified within the period of Board eligibility established by their specialty Board, with the exception of Emergency Room Physicians who must meet one of the two following tracks.

Track 1 Board Certified or Board Eligible

Track II

1. Successful completion of approved Residency
2. Board Certified at least once. (Does not have to be currently Board certified or Board eligible.)
3. Work experience in Emergency Medicine for at least two years.

Medical Education: Recognize current Physician's Tennessee license as meeting required CME hours. Reference Bylaws Article II, Part A. Section 2 A (8) and (10).

ARTICLE II

RECORD KEEPING

1. Preparation of Medical Records

The attending Medical Staff member shall be responsible for a completed medical record reflecting the diagnosis, diagnostic test results, therapy and patient's condition.

2. History and Physical Examination

A) The member of the Medical Staff admitting a patient must assure that a complete and current medical history and a complete and current physical examination of the patient are carried out by an appropriately credentialed practitioner with privileges at this hospital. The complete history and physical examination shall be in the patient chart within twenty-four (24) hours of admission or prior to any operative procedure, whichever occurs first.

B) A complete history shall include: chief complaint, history of present illness, current medications, allergies, past history, social history, family history, and system review.

C) A complete physical examination shall include such examinations and tests as the attending physician deems appropriate taking into account the patient's medical condition, age and medical history. The Attending Physician's impressions on admission and course of treatment plan shall also be included.

D) A legible written, dictated or electronically entered medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after hospital admission, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes, or absences of changes, is acceptable when

the history and physical examination is completed greater than 24 hours before and within 30 days of admission.

E) Appropriately credentialed and privileged members of the APP staff may perform the history and physical. To accept this history and physical the Attending Physician must sign, date, and time the document. The Attending Physician accepting this history and physical retains accountability for the accuracy and appropriateness of the documented history and physical.

F) Life or death emergency situations may preclude performance of a complete history and physical examination. In such emergency situations, a clinically pertinent note (such as an emergency medical screening note, an Emergency Department's physician note or a progress note) is acceptable. Under these circumstances, the full and complete history and physical shall be documented in the medical record as soon as is practical after the emergency situation has stabilized but within 24 hours of admission.

3. Progress Notes

Pertinent notes shall be recorded at the time of observation of the patient, sufficient to denote patient changes, both in frequency and detail, and to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. The initial progress note may be replaced by a completed History and Physical, at the physician's discretion.

Progress notes shall be written at least once a day or more frequently, if indicated by the patient's condition. In all instances, the content of the medical records shall be sufficient to justify the diagnosis and warrant the treatment and end result.

4. Discharge Summary

The discharge summary shall concisely relate the reason for hospitalization, significant findings, procedures performed and treatment rendered, the condition of the patient on discharge, final diagnoses and procedures and any instructions given to the patient and/or family. Documentation of post-hospital instructions as to physical activity, medications, diet and follow-up care shall be recorded in the chart and the discharge summary shall be dictated within thirty (30) days of discharge.

For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the final diagnoses and procedures, the outcome of the hospitalization, the case disposition, and the provisions for follow-up care.

For surgical cases performed on an outpatient basis, the summary may be incorporated into the operative report.

For patient stays less than 24 hours, the H&P and the Discharge Summary can be combined into one document including all criteria to meet compliance, by the discretion of the physician.

5. Report of Operation

All operations performed shall be fully described in the dictated operative report, to include a detailed account of the findings at surgery, as well as the details of the procedure used. Also included should be documentation of the names of the primary operating physician, surgical assistants, specimens removed or altered, name of procedure performed, pre-and post- diagnosis, any complications, as well as estimated blood loss and type of anesthesia used. Operative reports are to be dictated promptly following surgery and placed on the patient's chart within 48 hours of surgery.

A progress note will also be done by the physician immediately following surgery to be placed in the chart to provide pertinent information for anyone required to attending the patient while awaiting transcription of the operative report and placement of that report in the chart. The progress note will contain, at a minimum, the name of the surgeon and assistant, findings, technical procedures used, specimens removed, and post-operative diagnosis as well as estimated blood loss and type of anesthesia used.

6. Dating and signing of Clinical Entries

All clinical entries in the patient's medical record shall be legible, accurately dated and authenticated by the responsible staff member by the close of the chart.

7. Release of Medical Information

Written consent of the patient or a legally responsible party is required for the release of protected health information (PHI) to persons not otherwise authorized to receive such information.

8. Staff Member Access to Medical Records

Access to 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 information concerning individual patients.

All such projects shall be approved by the Medical Staff before records may be studied. Former members of the Medical Staff shall be permitted access to

information for the medical records of their patients covering periods during which they attended patients in the hospital.

9. Custody of Medical Records

Medical Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a lawful subpoena, court order or as otherwise specified by Federal or State law.

10. Use of Abbreviations and Symbols

A list of "Do Not Use" abbreviations, acronyms, and symbols will be approved by the Medial Staff and monitored for compliance.

11. Completion of Medical Records

Completion of the medical records shall conform with the Tennessee Rules and Regulations for Hospitals and Nursing Homes and The Joint Commission Standards for Hospital, Nursing Home and Home Care Accreditation, as follows:

- History and Physical examination report within twenty-four (24) hours of admission;
- Operative report dictated promptly following surgery and put on chart timely. A progress note will also be done by the physician immediately following surgery to be placed on the chart to provide pertinent information for anyone required to attending the patient while awaiting transcription of the operative report and placement of that report in the chart. The progress note will contain, at a minimum, name of primary surgeon and assistants, findings, technical procedures used, specimens removed, and post-operative diagnosis, as well as estimated blood loss and type of anesthesia used.
- Discharge summary will be completed within thirty (30) days of discharge, or twenty-four (24) hours of transfer to another facility.
- All charts must be completed within thirty (30) days of discharge.

All medical records of discharged patients incomplete for any reason thirty (30) days after discharge date shall be defined as delinquent.

12. Automatic Suspension of Privileges

Timely completion of patient diagnoses, illness and treatment is relevant to the quality of patient care and various outside regulatory requirements make timely completion of medical records a prerequisite to reimbursement.

Therefore, lest the quality and appropriateness of patient care be questioned or the financial stability of the Hospital be imperiled, automatic suspension of admitting and inpatient privileges, as provided for in the Medical Staff Bylaws may be

imposed by the Hospital for Staff members failing to complete medical records within thirty (30) days from the date of discharge.

- The Chief Executive Officer notifies the practitioners by certified, receipted mail of incomplete medical records that need to be completed within 30 days.
- If a practitioner's medical records remain incomplete past the suspension deadline, the practitioner's privileges to admit patients may be suspended and the suspension of admitting privileges shall remain in effect until all delinquent medical records have been completed.
- The admitting office (Registration) shall be notified of this action.

ARTICLE III

GENERAL CONDUCT OF CARE

1. A consent form, signed by the patient or on his/her behalf by someone authorized to do so shall be executed for every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained as in the case of an unaccompanied minor, an unconscious patient, there should be evidence in the record. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure shall be obtained. Appropriate forms for such consents shall be available.

2. A special consent form should be completed for patients undergoing surgery or any other potentially hazardous procedure.

3. All orders for treatment shall be in writing. A verbal order shall be acceptable if dictated to licensed nurses (may take all orders), pharmacist (may take medication orders only), registered or certified therapists (may take only orders pertaining to the therapy they are providing), certified dietary manager and/or registered dietitian (may record diet orders which have been discussed with the practitioner) social worker (may accept a verbal order from a practitioner for discharge planning and post hospital referrals) by the responsible practitioners. Registration Clerks are allowed to document verbal diagnoses given by the responsible practitioner. Licensed Radiologic Technologist and or Certified Nuclear Medicine Technologist may take orders pertaining to the service they are providing. All orders dictated over the telephone shall be signed by the nurse or the personnel approved to accept verbal orders to whom dictated with the name of the practitioner per his/her own name. The responsible practitioner shall authenticate all verbal orders prior to closure of the medical record.

4. All previous orders are automatically canceled when patients go to surgery and must be rewritten.

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or American Medical Association of Drug Evaluation. Experimental and investigational drugs may be used only when a protocol for their use has been (recommended by the pharmacy and therapeutics committee), approved by the Medical Staff and the concerned patient or his/her family gives written consent for its use. Unless specifically ordered by the attending physician, no patient will take any medications while hospitalized other than those administered by authorized nursing personnel and his/her physician.

6. Any qualified practitioner with clinical privileges in this hospital can be called for consultation.

7. Except in an emergency, consultation is required in the following situations:

    a. When the patient is not a good risk for the 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 procedures to be utilized.
    d. In unusually complicated situations where specific skills of other practitioners may be needed.
    e. Instances in which the patient exhibits severe psychiatric symptoms including suicidal tendencies or attempts, severe depression or agitation.
    f. When requested by the patient or his/her family.

8. All requests for consultations shall state the reasons for consultation.

9. All requests for consultation shall state the time frame within which the consult should be accomplished. There are two established time frames: ASAP (as soon as possible) and within twenty-four (24) hours.

10. All requests for consultation shall be responded to within twenty-four (24) hours: Reason for delay should be noted in the chart by consulting physician. All consultants not responding to requests within twenty-four (24) hours will be re-notified.

11. All requests for consultations shall specially state the intended extent of the consultation.

12. If the reason, extent and time frame of the requested consult is not stated and cannot be obtained the consultation will be assumed to be a full consult within twenty-four (24) hours.

13. The requesting physician is responsible for obtaining the patient/family member or responsible parties' verbal consent for the consult.

14. All requests for consultation determined to be ASAP by the requesting physician, require the requesting physician to personally contact the consultant providing the reason(s) for the consultation, the guidance, which is sought, the key clinical issues, and the relative urgency of the consultation.

15. All requests for consultation determined to be needed within twenty-four (24) hours by the requesting physician, require the requesting physician to provide written reason(s) for the consultation, the guidance which is sought, and the key clinical issues. It is inappropriate for the referring physician to delegate the communication of the consultation request to another hospital staff member, such as a nurse, ***unless*** the physician also communicates the above details to the consultant him/herself.

ARTICLE IV

EMERGENCY SERVICES

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Medical Staff shall have overall responsibility for emergency medical care.

2. The duties and responsibilities of all personnel serving patients within emergency area shall be defined in a provided procedure manual relating specifically to this outpatient facility. The content manual shall be developed by a committee of the Medical Staff, including representatives from nursing service and administration. When approved by the Medical Staff and by the Governing Body, it shall be appended to this document.

3. Physicians are not to charge for and are not entitled to charge for, services rendered pursuant to emergency codes, such as a "Code Blue" unless they are permitted to do so by contract with this hospital.

4. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

    a. Adequate patient identification;

b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the hospital;
d. Description of significant clinical, laboratory and roentgenologic findings;
e. Diagnosis;
f. Treatment given;
g. Condition of the patient on discharge or transfer;
h. Final disposition including instruction given to the patient and/or his/her family, relative to necessary follow-up care. If transferred, names of receiving facility and receiving physician.
i. Document if the patient left against medical advice.

5. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

6. There shall be a quarterly review of emergency room medical records by the Emergency Room Committee to evaluate the quality of emergency medical care. Reports shall be submitted to the Medical Staff.

7. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee, which includes at least one member of the Medical Staff, the Director of Nursing Service or his/her designee and a representative from the hospital administration. When approved by the Medical Staff and Governing Body, the plan shall be appended to this document.

8. Appropriate physicians shall be assigned to posts in the hospital approved by the Chief of Staff. It is their responsibility when so notified to report to their assigned stations. All other physicians will be assigned as needed according to the disaster response. The Chief of Staff in the hospital and the Chief Executive Officer or his designee of the hospital work as a team coordinating activities and giving direction. In case of evacuation of patients from one section of the hospital to another or the evacuation of the hospital premises, the applicable Medical Director of departments during the disaster will authorize a movement of patients by the Chief Executive Officer or his designee of the hospital and the Chief of Staff, in their absence the Vice-Chief of Staff and the alternate in administration, or next in line of authority respectively. All physicians on the Medical Staff of the hospital specifically agree to relinquish direction of professional care of their patients to the Chief of Staff in case of a disaster emergency.

ARTICLE V

ANESTHESIA AND SURGICAL SERVICES

A. ANESTHESIA

1. Pre-anesthesia Care

The medical records of all patients to be administered anesthesia shall contain a pre- and post- anesthesia note by a licensed practitioner, indicating a review of objective diagnostic data, an interview with the patient to discuss the patient's medical, anesthetic and drug history, a review of the patient's physical status, the choice of anesthesia for the contemplated procedure and follow-up of the patient's condition after surgery.

Anesthesia informed consent is documented in the medical record according to organization policy. The patient medical record documents discussions about anesthesia, blood transfusion options, risks and alternatives.

Physicians who maintain privileges to perform surgical/invasive procedures shall sign off on the anesthesia plan of care prior to the commencement of the procedure. Any practitioner non-compliant with The Joint Commission requirement will not be allowed to exercise surgical/invasive privileges.

2. The surgeons with input from the chief anesthetist and the nurse supervisor of the Surgery Department shall be responsible for the following:

- Reviewing privileges for all individuals with primary anesthesia responsibility. Requests for anesthesia functions shall be processed through the Medical Staff;
- Monitoring the quality of anesthesia care rendered by anesthetists anywhere in the hospital;
- Developing regulations for anesthetic safety;
- Assuring evaluation of the quality and appropriateness of anesthesia care throughout the hospital.

3. Supervision of Nurse Anesthetist (Director of Anesthesia Services)

Anesthesia services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of Osteopathy (DO). The director will be an active member of the medical staff with unrestricted privileges in a surgical specialty; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in a orderly and civil manner.

The operating physician shall be responsible for the direct supervision of the nurse anesthetist.

4. Medical Staff Approval of Anesthesia Safety Regulations

Anesthesia safety regulations developed by the surgeons with input from the chief anesthetist and the nurse supervisor of the Surgery Department shall be approved by the Medical Staff.

5. Non-Physician Members on the Operating Team

When the operating/anesthesia team consists of non-physicians, such as a podiatrist or dentist with a nurse anesthetist, a physician is immediately available in the facility in sufficient time to provide care in the event of a medical emergency, e.g., cardiac standstill or cardiac arrhythmia.

B. SURGICAL SERVICES

1. History and Physical Examination

If documentation of a completed history and physical examination is not evident, the surgical case shall be canceled by the operating room supervisor until the responsible practitioner completes a History and Physical as described in Article II (2).

2. Required Laboratory Testing

No patient shall be operated upon unless the medical record contains reports of appropriate lab work, which shall be at the discretion of the attending physician, completed not more than seven (7) days prior to the time of surgery. Lab reports from a CLIA approved Lab will be accepted.

3. Informed Surgical Consent

Written and signed informed surgical consent shall be obtained prior to the operative procedure except in emergency situations. In emergencies involving a minor or an unconscious, or otherwise incompetent patient in which consent for surgery cannot be immediately obtained from parents, guardians or next-of-kin, the circumstances shall be fully explained on the medical record. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken.

4. Informed Consent for Additional Surgery

Should a second or any additional operation be required during the patient's hospital stay, a new consent specifically worded should be obtained for the additional surgery. If two or more specific procedures are to be carried out at the same time, and this is known in advance, they may all be described and consented to on the same form.

5. Patient Identification and Operation Worksite

In accordance with hospital policy, the circulating nurse shall ensure that the attending physician has verified the patient's name, operative site and the procedure to be completed.

6. Pregnancy Testing Prior to Surgery

It is recommended that all female patients of child-bearing age receive a pregnancy test prior to any GYN surgery and that such results be reported in the medical record prior to surgery. Such test remains, however, at the discretion of the attending surgeon.

7. Preoperative Surgical Evaluation

The attending physician performing the surgical procedure shall perform a pre-operative evaluation visit and physical examination of the patient within seven (7) days prior to surgery.

8. Diagnostic Test Results

The results of laboratory, radiology and other pertinent tests ordered shall be reported in the medical record and reviewed by the attending surgeon before the case is started.

9. Pre-Operative Diagnosis

The pre-operative diagnosis shall be recorded in the medical record prior to surgery by the licensed independent practitioner responsible for the patient. An operative progress note is entered into the medical record immediately following surgery to provide pertinent information for anyone required to attend to the patient.

10. Tissue Examination

All tissue removed during surgery, except those approved and posted by the Medical Staff as being unnecessary for pathological examination, shall be promptly forwarded to the Pathologist, who shall appropriately examine the specimen and arrive at a pathological diagnosis, to be reported in writing. All tissues shall be accompanied by properly executed request slips.

11. Post-Operative Care

Inpatients and outpatients receiving general anesthesia will remain in the Recovery Area according to guidelines outlined in the anesthesia policy and procedure manual. Deviations will be at the discretion of the surgeon, with sufficient documentation in the patient record.

12. Emergency Conditions

In any emergency, patient care and the emergency procedure take precedence over medical record documentation, but such documentation should be done at the earliest possible time and should attest to the emergency nature of the care.

13. Dental and Podiatric Surgical Patients

Dental and Podiatric patients are a dual responsibility involving the dentist and/or podiatrist and a physician member of the Medical Staff.

a. Dentist's Responsibilities
   - A detailed dental history justifying hospital admission;
   - A detailed description of the examination of the oral cavity and pre-operative diagnosis;
   - A complete operative report;
   - Progress notes as are pertinent to the oral condition; and
   - Discharge summary.

b. Podiatrist's Responsibilities
   - A detailed podiatric history justifying hospital admission;
   - A detailed description of the examination of the foot and pre-operative diagnosis;
   - A complete operative report;
   - Progress notes as are pertinent to the oral condition; and
   - Discharge summary.

c. Physician Responsibilities
   - A medical history pertinent to the patient's general health;
   - A physical examination to determine the patient's condition prior to anesthesia and surgery; and
   - Supervision of the patient's general health status while receiving hospital services.

14. Outpatient Surgery

Surgical selection of patients for outpatient surgery shall follow the criteria below:

- Acceptable anesthesia risk for procedure being performed;
- No blood transfusions anticipated; and
- Hospital admission not anticipated.

ARTICLE VI

GUIDELINES FOR CREDENTIALING ALLIED HEALTH PROFESSIONALS

FUNCTIONS AND TASKS OF PHYSICIAN EXTENDER (PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS)

A Physician Extender is a person, other than a Licensed Independent Practitioner, who is qualified by training to assist a Physician or Dentist in rendering patient services. Such services are to be rendered only under the supervision and direction of a Physician or Dentist who is an Active medical staff member. The Physician or Dentist will be responsible for the performance of that Physician Extender. It is to be emphasized that the Physician Extender per se is not granted privileges. The Physician or Dentist is granted the privilege of utilizing a Physician Extender in rendering service to his/her patients. Duties assigned to the Physician Extender are limited to the services and functions normally performed facility-wide by the Physician or Dentist. Courtesy Staff physicians may utilize a physician extender when supervised on the hospital's premise.

ADVANCED PRACTICE PROFESSIONAL STAFF

The Advanced Practice Professional (APP) staff at Claiborne Medical Center consists of advanced practice nurses, physician assistants and certified registered nurse anesthetists (NP,PA, CRNA). APP's are credentialed and privileged through a process similar to the Medical Staff process. Optometrists are also part of the APP staff and may request privileges in the Hospital and the Nursing Home (ECF).

Physician supervision requirements as described in the Covenant system APP Guidelines policy do not apply to Optometrists. Optometrists will be subject to the focused evaluation process (FPPE) upon initial appointment and the granting of any new privileges.

OPTOMETRISTS

Privileges granted to Optometrists shall be based on their training, experience, demonstrated competency and judgment. Optometrists may not admit patients/residents to the facility. However, optometrists may perform services within the scope of their specifically delineated clinical privileges for patient/residents admitted by physicians or

dentists at the request of such practitioner in the Hospital and in the Nursing Home (ECF).

ARTICLE VII

AGENDA

A. The agenda at any regular Medical Staff meeting shall be:

1. Dinner; Guests
2. Call to order;
3. Acceptance of the minutes of the last regular meeting and of all special meetings;
4. Chief of Staff's report;
5. Administrator's report;
6. Committee reports;
7. Credential report;
8. Nursing report;
9. Medical Record report;
10. Old Business;
11. New Business;
12. Adjournment.

B. The agenda at special meetings shall be:

1. Reading of the notice calling the meeting;
2. Transaction of business for which the meeting was called;
3. Adjournment.

C In addition to Committees mandated by Medical Staff Bylaws. Standing Committees are appointed by the Chief of Staff. Standing Committees are to meet current needs and can be changed at any time. Standing committees are as follows:

A. Invasive Procedure Case Review
B. Ethics Committee
C. Acute Care Committee
D. Infection Control Committee
E. Pharmacy & Therapeutics Committee
F. Quality Management Committee

ARTICLE VIII

CODE OF PROFESSIONAL CONDUCT

INTRODUCTION

Claiborne County Hospital and Nursing Home is committed to the core values of excellence, service, teamwork, and integrity. Claiborne County Hospital and Nursing Home values its employees and recognizes their contributions and their rights to prosper and obtain personal and professional goals in a clean, safe, and healthy environment. We further value our physician partners and seek to maintain strong and respectful relationships with them and with all healthcare professionals. We value diversity of ideas and cultures and encourage open communication based on trust and equality to foster improvement.

The Governing Board of Claiborne Medical and Nursing Home recognizes that the stress of patient care situations can sometimes generate tense interactions and conflict among healthcare givers, family members, and other individuals. It is the desire of Claiborne County Hospital and Nursing Home Board of Directors that this Code of Professional Conduct will define the expectations of the working relationships within appropriate behavior so that members of the healthcare team work effectively, efficiently, and harmoniously to provide high quality care for patients in an environment of mutual respect.

As health care workers we have the unique privilege to have the opportunity to provide healthcare services for residents of our community, our family, and peers. Therefore, it is important to remember that we are all gentlemen and ladies providing healthcare for other gentlemen and ladies.

PURPOSE

To acknowledge that the stresses of patient care can generate tense interactions among healthcare givers, family members, and other individuals. To provide a Code of Professional Conduct to be followed by all Claiborne County Hospital and Nursing Home healthcare providers as standards for appropriate behavior in the healthcare environment.

PRINCIPLES AND STANDARDS OF PROFESSIONAL CONDUCT

Each person working in the healthcare environment (including medical staff members and all employees of Claiborne County Hospital and Nursing Home entities, e.g., hospital, nursing home, home health, hospice, EMS, etc.; contractors, and other persons doing business with or providing care at any of the above listed entities) is expected to treat all other individuals in a respectful, civil manner.

1. Healthcare providers shall refrain from:

a. Unwelcome or inappropriate physical contact with other healthcare workers
b. Verbal or written (including email) abuse such as foul language or racial and ethnic slurs
c. Any criminal conduct directed towards or affecting the person or personal property of another
d. Inappropriate email or written comments or remarks about a fellow worker
e. Any other act which is reasonably likely to adversely affect the healthcare team or impede its ability to deliver quality patient care

A person working in the healthcare environment may address constructive criticism or comments to a healthcare worker or supervisor in a manner which will reasonably result in improvement for patient care and Claiborne County Hospital and Nursing Home operations.

1. A healthcare professional should:

    a. Give clear instructions to other healthcare providers when necessary for the care of the patient and needs of their family
    b. Provide professional guidance as necessary to assure appropriate care by members of the healthcare team.
    c. Discuss concerns about another healthcare provider with the provider or the provider's supervisor or the Department Manager in a private setting.

2. A healthcare professional shall refrain from:

    a. Behavior that is intended to intimidate, humiliate, or degrade another healthcare worker
    b. Entries in the medical record of a patient related to the conduct of another healthcare provider, which is not necessary to document the care of the patient.

A person working in the healthcare environment may address comments or criticisms concerning Claiborne County Hospital and Nursing Home to Management or to the Board of Directors in a manner reasonably expected to result in improvement in the organization.

1. A healthcare professional should:

    a. Discuss with medical staff officers or management representatives any concerns about the operation of Claiborne County Hospital and Nursing Home, services or policies
    b. Participate in Claiborne County Hospital and Nursing Home sponsored surveys, which help measure the level of service provided by

Claiborne County Hospital and Nursing Home so management and the Board of Directors receive valuable input from the professional staff.

2. A healthcare professional shall refrain from:

   a. Using the resources of Claiborne County Hospital and Nursing Home to prepare or disseminate criticism of Claiborne County Hospital and Nursing Home or its facilities outside the recognized channel of communication to the medical staff, Management or the Board of Directors
   b. Making unauthorized statements to the media or the public about Claiborne County Hospital and Nursing Home or an affiliate while purporting to act in an official capacity as an officer or agent of Claiborne County Hospital and Nursing Home.

IMPLEMENTATION

The Governing Board of Claiborne Medical Center and Nursing Home requests Medical Staff leadership of each subsidiary and affiliate to communicate this Code of Professional Conduct to our healthcare professionals, management, and other interested parties; to encourage adherence to this Code in furtherance of Claiborne County Hospital and Nursing Home's mission, vision, and values; and to develop an appropriate process and channel of communication to achieve adherence.

Failure to adhere to this Code may result in corrective action as described in the Medical Staff Bylaws, Article V, Corrective Action.

Revised 1/23/2015
Revised 5/29/2015
Revised 7/24/2015
Revised 9/25/2015
Revised 1/29/2016
Revised 1/26/2017