RULES AND REGULATIONS OF THE MEDICAL STAFF OF ROANE MEDICAL CENTER

The rules and regulations are a separate document and not considered a part of the medical staff bylaws as addressed under: “Article IX” “Rules and Regulations and Departmental Procedures”. (Effective December 1, 2008)

RULES AND REGULATIONS

The Medical Staff is responsible for following these approved rules and regulations. Instances where these rules and regulations have not been followed will be forwarded to the appropriate department for recommendations and actions.

1. Patients may be admitted only by Tennessee medical licensed doctors of medicine, osteopathy, or qualified oral and maxillofacial surgeons with Medical Staff privileges.

2. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. All clinical entries in the patient’s medical record shall be accurately timed, dated, authenticated, and legible. All entries in the medical record must be legible.

   All orders for treatment shall be in writing. Verbal orders shall be given to a licensed nurse and authenticated within 48 hours by dating, timing and signing; however, if the hospital’s read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, no later than fourteen (14) days after the date of the verbal order. Other persons who are credentialed in their field of service may accept and document orders limited to the scope of their specific training and license/certification. For example: Registered and certified respiratory therapists may take telephone or verbal orders concerning respiratory treatments.

5. Medical Staff members are responsible for providing continuous care for their patients. If and when patient care calls for expertise, opinions or skills outside the delineation of clinical privileges of the attending physician or when additional opinions are needed, the attending should document the rationale and request a consultation from another physician. Pertinent progress notes shall be recorded at the time of observation and be sufficient to permit continuity of care and transferability. Such notes should be written not less than: daily for acute care patients, weekly for swing bed patients, and as the patient’s condition warrants for those patients under hospice care.

6. All medical records shall be completed within 30 days of discharge. Any physician who has three (3) or more suspensions in one calendar year (January 1 – December 31) due to incomplete medical records as addressed in Article III. Part F. Section 1 of the Medical Staff Bylaws, will be referred to the Medical Executive Credentials Committee for consideration of additional sanctions.

7. The attending physician shall be responsible for the preparation of a complete medical record for each patient. The complete record shall include: identification data, history and physical, consultations, clinical laboratory findings, radiology and pathology findings, progress notes,

final diagnoses, condition on discharge and follow-up instructions, clinical summary, and autopsy report if applicable. A complete history and physical will include the following pertinent information: admitting diagnosis, chief complaint, history of present illness, past medical history, family/social history, medications, drug allergies, review of systems, physical examination and plan.

Residents, Interns and Medical Students may document in the record as follows:

	History & Physical	Progress Notes	Orders	Discharge Summary
Medical Students	Documentation only on student documentation form. Student documentation form is not part of the permanent record.	Documentation only on student documentation form. Student documentation form is not part of the permanent record.	Medical students may not write orders.	Documentation only on student documentation form. Student documentation form is not part of the permanent record.
Interns	May perform with follow-up note from attending physician written within the next 24-hours	May write with the attending to co-sign on the next visit.	May write orders.	May write or dictate with co-signature required
Residents	May perform with follow-up note from attending physician written within the next 24-hours	May write with the attending to co-sign on the next visit.	May write orders.	May write or dictate with co-signature required

All entries in the medical record must be signed, dated, and timed.

8. A complete history and physical examination shall be written or dictated within 24 hours after admission of the patient but prior to any procedure requiring anesthesia.

A History and Physical which is performed up to, or no more than 30 days, before admission may be utilized, provided it is updated to reflect the patient's status within 24 hours after admission or registration but prior to any surgery or procedure requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.

9. When such history and physical examinations are not recorded before the time stated for the operation, the operation shall be canceled unless the attending physician states in writing that such a delay would constitute a hazard to the patient.

10. All records are the property of the hospital and shall not be taken away without permission or court order. The medical records shall be confidential, current, and accurate. Written consent of the patient is required for the release of medical information to persons not otherwise authorized to receive this information. In case of readmission of a patient, all previous records shall be available for the use of the attending physician.

11. All tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis and he shall sign his report. Teeth, newborn foreskin, orthopedic hardware, foreign bodies, cataracts, toenails, fingernails, scar revisions, hernia sacs, spermatic cord lipomas, wound debridements, small bony spurs, skin tags, placentas that are grossly normal, subcutaneous tissue and excessive skin removed during panniculectomy, products of arthroscopic or meniscal shavings, products of total and partial knee replacement, cartilage removed in nasal septoplasty, and atherosclerotic plaque are exceptions

12. Patients shall be discharged only on order of the attending physician. The supervising physician must evaluate the patient and document the plan of care within twenty-four hours prior to patient's discharge.

13. In concert with the needs of the community (through strategic planning), the hospital will admit those patients with diseases and surgical needs (based on patient's age and complexity of the case) within the financial constraints and scope of the hospital's ability to provide the services with available competent staff, and appropriate equipment and space. The hospital will transfer those patients requiring services not provided at this facility.

14. Surgeons should be in the operating room and ready to commence operation at the time scheduled. The operating room will be held for no longer than 15 minutes after the time scheduled except for extenuating circumstances.

15. All primary-care physicians on the active medical staff shall be assigned to the emergency room back-up duty on a rotating basis. Assignments shall be from 8 a.m. to 8 a.m., and the dates shall be posted at least one month in advance by the chair-person of the ED Committee.

Back-up duty includes:

1. being available for back-up for the Emergency Department in the event of an officially declared emergency in which the emergency management plan of the hospital has been initiated
2. providing follow-up for those patients seen in the ED without a designated physician.
3. providing follow-up for patients who are hospitalized under the hospitalist without a designated physician.
4. responding to urgent or emergency situations within the hospital if additional assistance is needed after notifying the ED physician and the Hospitalist on shift.

16. No physician shall be excused from Emergency Department duty except those who have reached the age of 65 and request to be excused, or those who are excused by the majority of the vote of the physicians who are themselves required to accept ED duty. All non-primary care physicians on the active medical staff shall be available, or have someone available for them, for ED duty on a rotating basis within their own specialty. All non-primary care physicians on the courtesy medical staff shall be available or have someone from their specialty available for consultation.

17. If the ED back-up physician should choose to admit any patient from the ED to the hospital, the patient shall become a part of his own service. Those patients who have expressed preference for another physician shall have such preferences honored at the earliest practical time, commensurate with good medical care.

18. Any physician who plans to be unavailable will arrange for another physician who is appropriately credentialed to provide care for his patients. The name of the physician who accepts this responsibility shall be made known to the ED and the nursing units prior to the absence.

19. Incomplete medical records of a physician who has expired or for some acceptable reason is unable to complete his records will be treated in the following manner: The Medical Records Director will document on the chart the reason for its incompleteness and sign his/her name. The chart will be filed at this time.

20. Patients who are hospitalized at the time of the death of a physician will be reassigned to another physician's service by the appropriate department chairman.

21. These Rules and Regulations shall be reviewed by the Staff no less frequently than every two years.

22. All physicians shall be required to notify the Medical Staff Coordinator within 10 working days of notice of any involvement in professional liability action in which the physician is a defendant.

23. A physician on staff, responsible for the care of the patient, may sign orders given by another physician.

24. A physician shall be required to notify the Chief of Staff and Medical Staff Coordinator if he/she has voluntarily or involuntarily or terminated medical staff membership (at any facility), and/or if he/she has limitation, reduction or loss of clinical privileges, or any other type of professional sanction.

25. Any physician who violates HIPPA privacy regulations will be subject to review by the Medical Executive/Credentials Committee and possible disciplinary action.

26. All invasive and noninvasive procedures that place the patient at risk shall be described in writing by the performing physician immediately after completion of the procedure.

27. 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 or anesthesia; 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 an orderly and civil manner.

28. The screening of individuals seeking emergency medical care in the Emergency Department, for the purpose of determining whether the individual has an emergency medical condition that requires stabilizing treatment, shall be done by the Emergency Department physician, or by an appropriately credentialed Physician Assistant and/or Nurse Practitioner privileged to perform medical screening examinations working within the practitioner's approved scope of practice under the supervision of the Emergency Department physician. In the cases of pregnant patients in possible labor, the medical screening examination shall be done by the Emergency Department Physician.

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