LeConte Medical Center

Sevierville, Tennessee

Medical Staff Rules and Regulations

Revised
November 21, 2019

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I. General

Upon appointment to the Medical Staff at LeConte Medical Center ("LMC or "Hospital") and as often thereafter as necessary, each member shall arrange for coverage by an alternate Medical Staff member for his/her patients in such a member's absence. In the event the member cannot be reached within a reasonable period of time the alternate may be called in his/her place. If the alternate cannot be located, the Chief of Staff shall have the authority to call any member of the Medical Staff to care for the patient should he/she consider it necessary.

II Admissions and Discharges

A. Only members of the Medical Staff may admit a patient to this Hospital. The admitting Staff member shall be considered the attending Staff member. Advanced Practice Professionals may perform the initial evaluation of patients to be admitted. No patient will be admitted without a provisional admission diagnosis. The attending Staff member's name shall appear on the record summary. The attending Staff member is responsible for the care of the patient, unless otherwise documented in the physician's orders (i.e., transfer of service or coverage during the attending physician's absence). The attending Staff member or responsible practice group member will be responsible for completion of the medical record including the diagnosis validation and the discharge summary.

1. Any patient admitted to the Hospital through the Emergency Department (ED) by an ED physician will be admitted to the service of an attending physician for continuity of care at which point Rule II.A. shall apply.

2. Members have the privilege of admitting patients suffering from all types of diseases and illnesses, but may not admit patients for types of care that cannot safely be provided or are not available at the Hospital.

B. Patients admitted to the Hospital shall be the responsibility of the admitting Staff member or another authorized practitioner. Such practitioner shall be responsible for the medical care and treatment, for the completeness and accuracy of the medical record, for necessary special instructtions, and for transmitting reports of condition of the patient to the referring physician and to relatives. Whenever these responsibilities are transferred from one member of the Staff to another, a note to that effect shall be made on the patient's medical record.

C. The admission policy is nondiscriminatory. All patients who require inpatient medical care shall be admitted by members of the attending Staff, and shall be assigned to the services concerned in treatment of the disease that necessitates admission or treatment. Transfer between the various services may be made in accordance with the judgement of the attending physician on service.

D. Members admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients and Hospital personnel from those who are a source

of any danger whatsoever.

1. Patients with a tentative or confirmed diagnosis of a communicable disease will be admitted and placed in accordance with the Hospital infection control policies and procedures.

E. Patients shall be discharged only by order of the attending physician, or the designated responsible physician. The physician shall enter the final diagnosis on the chart, except when the diagnosis is un-clear due to pending pathology specimen or diagnostic study results.

1. When patients leave against medical advice, the policy of "Discharge Against Medical Advice" will be followed.

F. In the event of death of the patient occurring in the Hospital, the attending physician, or a Registered Nurse shall pronounce the patient dead within a reasonable time not to exceed thirty minutes.

1. No autopsy shall be performed without signed, written consent of the proper relative, or other persons authorized by law to order autopsies.

G. Guidelines for Organ/Tissue Donation at LMC are defined to assure that the option of organ/tissue donation is provided to the next-of-kin of all potential donors and that LMC is in compliance with Tennessee State Law 1140 and the Omnibus Act P.L. 99-509.

H. No minimum battery of tests or examinations shall be required for any categories of patients. Individual physicians may establish standard orders for selected patients and/or diagnoses.

III. Medical Records and Documentation

This policy applies to all members of the Medical Staff holding clinical privileges.
The policy also applies to advanced practice professionals (APPs).

I. General Keeping of the Medical Record

A. Completion and Signature Requirements

1. The attending physician shall be responsible for the preparation of a complete, legible medical record for each patient.

2. All entries shall be dated, timed and authenticated by the author of the entry.

3. A medical record is defined as complete at the expiration of thirty (30) days post discharge and all required documentation and authentication are present. The medical record is then determined to be a Closed Medical Record.

4. All clinical entries shall be accurately timed, dated and authenticated by signature, identifiable initials, or computer key. A rubber stamp of a printed name may be used to clarify a signature that might otherwise be illegible.

   No rubber stamp bearing an actual signature may be utilized. This regulation applies to both Inpatient and Outpatient charts and orders.

5. A list of unapproved/unacceptable abbreviations is identified below. Other abbreviations may be used. If the abbreviation is unclear, the author is to be contacted and the abbreviation clarified then documented within the record. Please refer to the Covenant Health policy on abbreviations for complete information.

"Do Not Use" Abbreviations include:

Abbreviation	**Preferred Term**
U (for unit)	"unit"
IU (for international unit)	"international unit"
Q.D. (once daily) Q.O.D. (every other day)	"daily" and "every other day"
Trailing zero (3.0 mg) Lack of leading zero (.3 mg)	Do not use a zero by itself after a decimal point (3 mg) and always use a zero before a decimal point (0.3 mg)
MS MSO4 MgSO4	"morphine sulfate" or "magnesium sulfate"

B. <u>APP Entries / Patient Care Requirements</u>

1. APP's may perform daily rounds under the supervision of the physician. Evidence of daily communication between the supervising physician and APP is required in the medical record.

   A supervising physician may choose for their APP (NP or PA) to perform daily rounds. The APP will function under the direct supervision of the collaborating physician/group. The phrase "under the direct supervision of a physician" shall be construed as a periodic evaluation and clinically appropriate follow-up of the medical plan of care. Factors influencing the frequency of this evaluation include the patient's condition during the course of the medical treatment and the patient's ability to understand his/her care. The supervising physician must be readily available for in

person consultation upon the request of any patient under the care of a physician-directed health care team.

2. Supervising physicians are required to co-sign the following APP entries no later than 30 days post discharge, except where noted otherwise
    a. discharge summary
    b. history and physical
    c. consults
    d. admission order

3. A physician co-signature is not required for APP orders or daily progress notes.

4. APP's are responsible for completion of their documentation and signature requirements, including their own verbal/telephone orders.

C. Documentation by Medical Students, Interns and Residents

1. Charting guidelines for these participants are as follows:

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

D. Administrative Closure of Medical Records

1. No medical staff member shall be permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable or other reasons.

2. HIM will make all reasonable attempts to complete every record, however, in the event a provider is no longer available, the record will be administratively closed. The appropriate Committee will be notified of all closed records.

II. Content of the Medical Record

A. The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record contains at least the following:

1. The patient's name, sex, address, date of birth, and the name of any legally authorized representative, allergies to foods and medicines, the patient's language and communication needs.
2. Records of communication with the patient regarding care, treatment, and services, (for example telephone calls or email) if available;
3. Patient-generated information (for example, information entered into the record over the Web or in previsit computer systems) if available;
4. The patient's legal status, for patients receiving mental health services;
5. Emergency care provided to the patient prior to arrival, if any;
6. The record and findings of the patient's assessment;
7. A statement of the conclusions or impressions drawn from the medical history and physical examination;
8. The reason(s) for admission or treatment;
9. The goals of treatment and the treatment plan; Evidence of known advance directives;
10. Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, including explanation of risks and benefits of the procedure/treatment and of the alternatives to the procedure/treatment;
11. Diagnostic and therapeutic orders, if any;
12. All diagnostic and therapeutic procedures and tests performed and the results;
13. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
14. Progress notes made by the medical staff and other authorized individuals;
15. All reassessments, when necessary;
16. Clinical observations, including the results of therapy
17. The response to the care provided;
18. Reports of all consultations provided;

19. Every medication ordered or prescribed for an inpatient;
20. Every dose of medication administered and any adverse drug reaction;
21. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
22. All relevant diagnoses established during the course of care; and
23. Conclusions at termination of hospitalization
24. Any referrals/communications made to external or internal care providers and to community agencies.

B. History and Physical

1. The member of 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.
2. The history and physical must be created no more than 30 days before the admission, or within 24 hours after admission, or registration, and in any event, prior to any surgery or procedure requiring anesthesia services.
3. H&Ps created within 30 days prior to admission must be updated by an appropriately credentialed practitioner with privileges at the hospital to include an examination for changes in the patient's condition. This update must occur within 24 hours after the admission or registration and prior to any surgery or procedure requiring anesthesia services.
4. Please note that a History and Physical must be signed (or cosigned, as appropriate) by the physician. The physician's signature on the H&P update does not satisfy the requirement for an H & P Update as outlined above. Both must be signed or cosigned.
5. Documentation of the history and physical, completed and updated as required herein, must be documented in the patient's record prior to any procedure involving risk and all procedures requiring anesthesia services.
6. With the exception of emergencies, patients shall not be taken to the operating room unless a compliant history and physical examination report appears in the record. In cases of emergency surgery, a brief admission note and evidence that a history and physical examination report has been recorded.

7. The H&P must contain, at minimum, the following:
    a. chief complaint;
    b. details of the present illness;
    c. allergies and current medications, including supplements;
    d. when appropriate, assessment of the patient's emotional, behavioral, and social status;
    e. relevant past, social, and family histories;
    f. pertinent review of body systems;
    g. appropriate physical exam as dictated by patient's clinical presentation or anticipated procedure to include, at a minimum, a documented examination of the heart and lungs; and
    h. conclusions or impressions, assessment and plans for treatment.

8. Documentation of informed consent, when applicable and appropriate

9. OB Records
    a. Obstetrical medical records shall include prenatal information. A durable, legible original or reproduction of the prenatal record is acceptable for use as the H&P, provided the patient has been seen within 30 days of admission.
    b. If a patient has a scheduled C-section, the H&P update process applies as outlined previously in this policy.

10. Minimally invasive procedures
    a. Procedures listed in Appendix A do not require an H&P unless anesthesia or moderate sedation is used. Moderate sedation as defined by CMS is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulations.
    b. A post procedure progress note / brief op note must be documented immediately after the procedure and must include:
        1) procedure performed
        2) pertinent findings
        3) estimated blood loss, if any
        4) specimens removed, if any
        5) complications, if any

c. Note that if the full operative/procedure report is created, immediately available and signed immediately after the procedure, the immediate post-op note (aka Brief Op Note) is not required.

11. Recurring 'outpatient in a bed' visits for infusions, transfusions and chemotherapy on stable patients require an updated progress note at a minimum of once per year.

C. Consultation Reports

1. Contain a recorded opinion by the consultant that reflects the examination of the patient and review of the patient's medical record.

D. Operative Reports

1. Must be recorded immediately following the surgical or invasive procedure, before the patient is moved to the next treatment area.

2. Must be recorded by the person who performed the procedure.

3. Shall contain

   a. the date of the procedure
   b. preoperative and postoperative diagnoses
   c. the procedure(s) performed
   d. a description of the procedure
   e. findings
   f. the technical procedures used
   g. specimens removed, if any
   h. estimated blood loss, if any
   i. complications, if any
   j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
   k. the name of the primary surgeon and any assistants

4. Postoperative Progress Notes / Brief Op Note

   a. In the event the full operative report has not been recorded, a postoperative progress note / brief op note shall be recorded by the surgeon immediately following the procedure and prior to transfer to next level of care. Note that if the full operative report is created immediately after surgery using front end dictation, the

postop progress note / brief op note is not needed.

b. Required elements

1) The procedure performed
2) Description of the procedure
3) Complications, if any
4) Estimated blood loss, if any
5) Findings
6) Specimen(s) removed, if any
7) Name of surgeon and any assistant(s)
8) Postoperative diagnosis

E. Anesthesia Documentation Requirements

1. Pre-Anesthesia Evaluation

a. Must be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure.

b. Required elements

1) Pre-procedural education
2) Patient's condition immediately prior to induction of anesthesia.

2. Post Anesthesia Evaluation

a. Shall be documented by a physician or CRNA qualified to administer anesthesia

b. Must be performed after the patient's recovery from anesthesia and no later than 48 hours following the procedure

c. Required elements

1) Respiratory function, including respiratory rate, airway patency, and oxygen saturation
2) Cardiovascular function, including pulse rate and blood pressure
3) Mental status
4) Temperature
5) Pain
6) Nausea and vomiting
7) Postoperative hydration

F. Diagnostic and Therapeutic Orders

1. Must be
    a. Typewritten, computer-generated, or handwritten in ink
    b. Dated, timed and signed by the ordering provider
    c. Clear and legible
2. Verbal and telephone orders
    a. Should be used only when absolutely necessary
    b. Must be cosigned within 14 days (current law and regulation) following the 'read back and verify' process.
        1) Must be cosigned by either the ordering provider or another provider responsible for the care of the patient.
        2) If the 'read back and verify' process is not followed, the orders must be cosigned within 48 hours.
    c. Please refer to Covenant Health's policy on Telephone and Verbal Orders for complete and detailed information.
3. Other persons listed below may take orders limited to their specific license, training and function.
    a. Physical Therapist
    b. Physical Therapy Assistant (PTA)
    c. Occupational Therapist
    d. Occupational Therapy Assistant (OTA)
    e. Psychologist
    f. Respiratory Technologist
    g. Respiratory Therapist
    h. Speech Therapist
    i. Pharmacist
    j. Radiology Technologist
    k. Ultrasonographers
    l. Nuclear Technologist
    m. Dietitian
    n. Sleep Techs
    o. Neuro Techs

G. Progress Notes

1. Must be recorded by an appropriately credentialed provider on a daily basis or may be documented more frequently based upon patient condition.
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.

H. Discharge Summary

1. Required for all inpatient and observation stays. In the event of a death, a Death Summary/Record of Death serves as the discharge summary.
2. Required anytime the patient stays after midnight due to clinical condition (e.g., after day surgery when clinical condition unexpectedly changes)
3. The provider who writes the discharge order is responsible for the discharge summary.
    a. When the discharge summary is dictated by the APP, the APP must include the name of the physician who should be flagged to cosign the report.
4. Must be in the record no later than 30 days post discharge
5. Required elements
    a. Reason for admission
    b. Principal diagnosis
    c. Secondary and chronic diagnoses that are treated/monitored, and whether the condition was new or present on admission
    d. Any complications and co morbidities
    e. Operative procedures performed
    f. Pertinent lab, radiology, test results and physical findings
    g. Course of treatment
    h. Condition at discharge
    i. Disposition
    j. Instructions given at discharge
    k. Final diagnosis without abbreviations or symbols

6. A short stay discharge summary will be accepted for stays of less than 48 hours, provided the stay was uncomplicated. The following elements are required:

    a. Outcome of the hospitalization

    b. Plans for follow up care

    c. Discharge Disposition

I. Coding Queries

1. Coding queries are necessary for complete and accurate coding and core measure abstraction. Unanswered queries are treated like other chart deficiencies. Providers may be suspended if these are left unanswered as addressed under Section III of this policy.

Access to the Medical Record

1. All patient records are the property of the hospital wherein the patient is treated and shall not be removed from that hospital except by court order, subpoena, or statute and in accordance with Covenant Health's policies.
2. Free access to all medical records of all patients shall be afforded to medical staff members in good standing, their extenders and students for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. *Access must be in accordance with Covenant Health's privacy and security policies, and includes only those patients for which the provider has a legitimate treatment relationship.*

III. TIMELINESS

In all cases the medical record shall be completed within 30 days following patient discharge or the physician/provider will be subject to the suspension process. APP's who are delinquent in completing medical records will not be allowed to assist their sponsoring physician(s) in the hospital until all delinquent records have been completed.

A. Notification of Providers

1. Providers shall be notified of all incomplete medical records on a regular basis, no less than monthly. Incomplete records must be completed prior to the date of suspension in order to avoid suspension of elective admission privileges.

B. Failure to Complete Records – Automatic Suspension

A suspension for incomplete medical records is considered to be administrative in nature and is not reportable to the National Practitioner Data Bank. This type of suspension is not related to professional competence or conduct that could adversely affect the health or welfare of the patient.

1. Failure to complete records by the suspension deadline results in an automatic administrative suspension of privileges.
2. HIM sends written notification of suspension to the physician's practice by fax or email. The notification includes the requirement for the physician to arrange for appropriate coverage for patients by another medical staff member with like privileges.
3. The automatic administrative suspension includes all admitting privileges and scheduling of any new procedures. The physician on suspension may continue to care for patients currently admitted to the physician's service for up to 15 days from the date of suspension. Admissions and procedures that have been scheduled prior to the date of suspension will be honored for up to 15 days after the date of suspension.
4. A suspended physician may continue to take emergency call and admit and care for patients in emergency situations.
5. A physician may not admit patients under the services of another physician or perform surgical or other invasive procedures when he/she is on the suspension list.
6. Reinstatement of these privileges is allowed immediately upon completion of all delinquent record(s). Suspension of these privileges cannot be based upon a minimum or maximum numbers of records to be completed. Any and all delinquent records are expected to be completed.
7. The suspension list will be distributed to the following areas/departments by Health Information Management:

    - Administration
    - Quality Care Management
    - Central Scheduling
    - Chief of Staff
    - Day Surgery
    - Emergency Department
    - Endoscopy Lab
    - Medical Staff Office
    - Outpatient Registration
    - Pre-admission Testing
    - Registration
    - Surgery

8. If a physician has been suspended for a third time in the calendar year, all clinical privileges are automatically relinquished until all

delinquent medical records are completed. The automatic relinquishment is not grounds for a fair hearing and is not reportable to the NPDB. *(Refer to Credentials Policy, 6.F AUTOMATIC RELINQUISHMENT)*

9. Reinstatement from the automatic relinquishment may be requested upon completion of all delinquent medical records. The request is to be submitted through Medical Staff Services. Payment of a fine may be required as determined by the MEC.

10. If the physician does not complete all delinquent records within 60 days after the automatic relinquishment is in effect, the matter will be referred to the MEC and may be considered an automatic resignation from the medical staff.

APPENDIX A

I. Minimally invasive procedures that DO NOT require an H&P

A. Minimally invasive procedures as listed below do not require a history and physical. An immediate post-procedure progress note should be written to include, at minimum:

1. the name of physician performing procedure,
2. procedure performed, and
3. any other pertinent medical findings or events.

B. Minimally invasive procedures are defined as all:

1. Epidural steroid injections or diagnostic injections
2. Nerve root blocks, sympathetic blocks, IV regional blocks
3. Image guided biopsy, image guided drainage, image guided aspiration
4. Myelograms, lumbar punctures
5. Arthrocentesis, joint injections, arthrograms
6. Central venous line, Q Port flush
7. Newborn circumcisions
8. EEG
9. Esophageal motility studies, rectal motility studies
10. Labor checks
11. Manometry
12. Tilt table test
13. Breast biopsy if no sedation
14. Apheresis
15. Aspiration
16. Biliary tube change
17. Blood patch
18. Coronary CTA
19. PFT
20. Fistulogram
21. Gastrotomy tube replacement
22. Nephrostogram
23. Paracentesis, thoracentesis
24. PEG tube replacement
25. Perma cath removal

26. Percutaneous transhepatic choangiogram
27. Pill cam
28. PICC line placement
29. Spirometry
30. Stress test
31. Ureteral stent placement
32. Venogram
33. pH study
34. Bone marrow biopsy

II. <u>Procedures that DO require H&Ps include, but are not limited to:</u>

A. Any procedure involving sedation requires an H&P (including radiology).

B. Angiogram

C. Device implants (e.g., pH probe)

D. Heart catheterization

E. Chemotherapy, blood transfusions and drug infusions

1. Stable patients receiving any of the above on a regular basis require an H&P or updated progress note once a year.

IV. General Principles Of Medical Care

A. All drugs and medications administered to patients shall be those listed in the latest edition of the "United States Pharmacopoeia", "National Formulary", or "New Nonofficial Drugs" or those approved for marketing by the Food and Drug Administration. Drugs for investigational use will be handled in accordance with principles developed by the American Hospital Association and the American Society of Hospital Pharmacists. Reports concerning any investigational drug will be submitted as required by the Food and Drug Administration. Investigational drugs need to be approved by the IRB.

B. All orders for medications and treatments shall be recorded by the responsible physician, dentist, APP, or consultant and signed. Verbal orders shall be dealt with as in Rule III.B.10 and Rule III.B.11.

C. At the time of operation, all previous orders are cancelled.

D. Psychiatric and/or mental health consultations and treatment will be requested for all patients who have attempted suicide or have taken a chemical non-alcoholic overdose unless the patient refuses in writing or unless mitigating circumstances are outlined in writing in the chart. Mental health consultations in such situations may be performed by Psychologists, Masters of Social Work, and Psychological Examiners licensed by the Board of Healing Arts of the State of Tennessee and credentialed through the Medical Staff. They may be permitted to exercise privileges only under the direct supervision of physician staff members.

V. Surgery

The following rules governing procedure and conduct in the operating rooms of LeConte Medical Center have been assembled with one prime consideration- the welfare of the surgical patient. All other considerations are secondary.

A. Questions as to policies and procedures in the operating rooms at LeConte Medical Center are under jurisdiction of the Surgical Quality Improvement Committee. No change to policies or procedures shall be made without the authority of this committee.

B. No operating time or bed space shall be allotted to any physician or dentist except for specific case.

C. With the exception of emergencies, all surgical operations must have prior written consent of the patient or his legal representative. Please also see Rule III.B.4.

D. The decision as to what constitutes an emergency is to be made by the attending surgeon scheduling the case and the head nurse in charge of the operating room. In case of disagreement between the two, the decision is to be made by the Medical Director of Surgery, or if he/she cannot be reached, the Chief of Staff or his/her designee.

E. Emergencies take priority over all other surgeries at all times.

F. Operating time may be forfeited when the start of the operation is delayed for more than fifteen (15) minutes by the absence of one or more of the essential members of the operating team. Surgeons are required to call the operating room if they anticipate being fifteen (15) minutes or more late. If the Medical Director of Surgery is not present or available, the operating room supervisor will determine an alternate time or forfeiture.

G. Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. The limited categories of specimens that may be exempted include the following: specimens that by nature of condition do not permit fruitful examination, such as cataract,

orthopedic appliance, foreign body, intrauterine device, toenails, teeth, or grossly normal placentas.

H. The operating surgeon and anesthetist are required to check their patient's identity before Administering anesthesia and starting the operation. The circulating nurse is to confirm the patient's identity as he/she enters the operating room and notify the surgeon.

I. No spinal anesthesia may be given unless there is a designated person other than the surgeon to watch the patient's condition. Such person may be anyone authorized by the surgeon and credentialed by the Medical Staff to do so.

J. Any patient who has had an operation under a conductive or general anesthesia shall go to the recovery room or to an area where recovery services are available.

K. No one is to enter an operating room during surgery without operating suit, cap and mask; or gown, cap, and mask for observers, and conductive shoes or shoe covers.

L. Visitors in the operating room are to be kept to a minimum and restricted to those persons whose presence is expressly approved by the patient, operating surgeon, and the acting operating room supervisor. The visitor's presence is for observation purposes only.

M. Infringements of these rules are to be reported by the operating room supervisor to the Medical Director of Surgery or to the Chief Administrative Officer. If they cannot handle the infringement, then the matter is to be referred to the Medical Executive Committee.

N. It shall be the responsibility of the operating surgeon to have a qualified assistant in attendance during operations, which, in his/her judgement, present unusual hazards to the patient.

O. The attending surgeon will be responsible for evaluating the patient as to the patient's need for surgery and anesthesia. Once this evaluation is made and recorded in the medical record, the anesthetist will evaluate the patient and choose the appropriate anesthesia plan-of-care in accordance with the AANA (American Association of Nurse Anesthetists) guidelines published by that organization.

P. In the event the operating surgeon is unable to continue with an operative procedure and no physician first assistant is present, a physician of the same specialty as the incapacitated physician shall be requested to attend the patient. If a suitable replacement of the same specialty is not available, a general surgeon shall be requested to attend the patient. If a general surgeon is unavailable, the physician on duty in the emergency department will be requested to attend the patient and, if necessary, stabilize the patient until relieved by another physician.

VI. Emergency Department and Emergency Services

A. The Emergency Department shall be staffed by (a) qualified physician(s) and (b) registered nurse(s) at all times, and such assistants as may be required.

B. Each specialty service, (OB, Cardiology, Family Practice, Internal Medicine, Hospitalist, Orthopedics, General Surgery, Urology and Otolaryngology) shall maintain a separate duty roster for emergency care. The rosters must be submitted to the Medical Staff Services Office by the twentieth (20^{th}) of the month prior to the scheduled month. If a roster is not submitted by that time, Medical Staff Services will make the roster. Medical Staff Services will distribute these rosters by the twenty fifth (25^{th}) of the month prior to the scheduled month.

C. It shall be the responsibility of the assigned physician to notify Medical Staff Services of any change from the posted duty roster and the Medical Staff Services Office will change the schedule accordingly and distribute changes to all departments.

D. If the assigned physician, while on duty, becomes unable to carry out their on call responsibility, they must immediately notify the Administrator on call and the Chief of Staff.

E. If an assigned physician cannot be located, the nurse will act in the following manner:

1. Call the alternate physician
2. Contact the Medical Director of that particular department.
3. Call the Chief of Staff who will either provide or find coverage.
4. Call the Administrator on call.

F. A copy of the Rules and Regulations concerning the Emergency Department and Emergency Services shall be available in the Emergency Department.

G. Emergency Department records must contain sufficient clinical information, treatment data, follow-up instructions, and condition of patient on discharge as to allow easy transferability of the patient from one physician's care to another.

H. When called by the ED physician for an admission, it is the responsibility of the on-call physician to admit the patient. If the on-call physician believes the admission is not appropriate, the on-call physician will come to the ED to evaluate the patient within the hour unless a mutually acceptable alternative to admission is agreed upon by both the ED physician and the on-call physician.

I. If a patient's medical condition, as determined by the ED physician necessitates an on-call physician to come to the hospital to evaluate and/or treat the patient for an emergent condition, it is expected that the on-call physician will come to the hospital and evaluate the patient immediately.

VII. Suspension Of Admitting Privileges

A. The member is referred to both the Medical Staff Bylaws and the Rules and Regulations section on Medical Records.

VIII. Delineation Of Privileges

A. The delineation of privileges forms to apply for clinical privileges are filed in Medical Staff Services and updated at each reappointment by the Credentials Committee.

IX. Inappropriate Behavior

A. It is the intent of the Medical Staff to prevent and eliminate inappropriate conduct that may disrupt hospital operations and/or interfere with optimal patient care. Medical Staff members, Medical Associates, and Medical Assistants are expected to refrain from inappropriate behavior. Inappropriate behavior subject to the Rules and Regulations shall mean any one or more of the following:

a. Sexual or other harassment of an individual or individuals that is based on race, color, gender, religion, pregnancy, national origin, age, or disability.

a. Violence (meaning behavior intended to cause harm to either person or property or Behavior bearing a substantial possibility of causing such harm, whether intended or not).

b. Threats of violence.

d. Carrying weapons.

e. Use of alcohol or any illegal drug or inappropriate use of controlled substances while on call or duty.

f. Inappropriate and disrespectful verbalization with respect to individual or individuals.

g. Failure to maintain confidentiality.

B. Incidents of inappropriate behavior will be reported to the Chief of Staff confidentially and without further publication or discussion of the report with others, except to the extent necessary to prevent recurrences or to protect the safety of any individual on hospital premises. Instances of violence, threats of violence, carrying weapons, and/or intoxication shall be reported to hospital security as well as the CAO and Chief of Staff. Any complaint of employee harassment must be reported to the Human Resources Department.

C. The Chief of Staff will report the instance(s) of inappropriate behavior to the Medical Executive Committee (MEC). After their evaluation, if the MEC determines the reported behavior(s) to be credible, the physician, medical associate, assistant will be notified. It is the responsibility of each committee member to maintain total confidentiality.

D. Nothing herein shall prohibit collegial or informal attempts to address inappropriate behavior. The MEC shall have the right to require the reported party to meet with the committee to discuss any aspect of the individual's behavior.

E. The MEC shall recommend one of the following courses of action in response to the reported behavior:

1. A letter reminding the physician, medical associate, or medical assistant of his/her responsibilities and the specific behavior(s) and event(s) in question is sent to the physician, medical associate, or medical assistant and a copy placed in his/her quality file.

2. The MEC may decide that a reported behavior is sufficiently egregious to warrant limitation of privileges or precautionary suspension even after a single incident.

3. The MEC may decide that repeated instances of inappropriate behavior should result in limitation or suspension of privileges.

4. Suspension or limitation of privileges shall be reported to the Board in accordance with Medical Staff Bylaws. The Hearing and Appeals Procedure shall apply.

F. Documentation of inappropriate behavior shall include:

1. Date and time of behavior
2. If the behavior affected or involved a patient in any way, the name of the patient.
3. The circumstances which precipitated the situation
4. A description of the behavior limited to factual, objective language as much as possible
5. The consequences, if any, of the behavior as it related to patient care or hospital operations
6. Record of any action taken to remedy the situation, including date, time, place, action, and names of those intervening.

G. This procedure shall apply only to instances of inappropriate behavior. Concerns related to clinical care of patients are to be referred to the Case Review Committee.

X. Enforcement Of The Rules And Regulations

A. Article X of the Medical Staff Bylaws provides that these Rules and Regulations shall have the same force and effect as the Bylaws.

B. Violation of the Rules and Regulations is subject to the same disciplinary measures described in the Bylaws.

XI. Amendment Of The Rules and Regulations

A. Amendment of the Rules and Regulations shall follow the same procedure described in Article VII of the Medical Staff Bylaws.