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.

ARTICLE II

RECORD KEEPING

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. APP Entries / Patient Care Requirements

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. <u>History and Physical</u>

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, with the exception of hospice patients (see bullet 3 below).
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.
3. For inpatient hospice patients, a physician progress note must be recorded, at a minimum, once a week. If a change in plan of care is necessary, such as diagnostic testing or medication orders, this will be communicated to the primary physician for evaluation and ordering.

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. <u>Minimally invasive procedures that DO NOT require an H&P</u>

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.

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.

<u>Consultations</u>

1. Consultation with other members of the medical staff shall be sought liberally and consistently with good medical practice.

2. A psychiatric consult must be requested for and offered to all patients admitted subsequent to an attempted suicide or chemical overdose, and this must be documented in the medical record.

3. All requests for consultations shall state the reason(s) for the consultation and pertinent patient information that will be meaningful for the consulting provider. Documentation in the record of meaningful history and physical findings that support the need for consultation should be included.

4. All requests for consults shall state the time frame within which the consult should be accomplished. There are three established time frames: STAT, ASAP, and routine.

5. Timing: STAT consults require immediate and direct provider to provider communication with an agreeable upon timeline. ASAP consults require direct provider to provider contact and shall be completed within 4 hours. Routine consults shall be completed within 24 hours.

6. If circumstances are such that the consulting physician determines that the consultation is not required for patient care, the consultation shall not be performed and the reasons therefore for such shall be promptly documented in the progress notes of the patient's clinical record be entered in the progress notes of the clinical records. It is recommended such decision and be discussed with the provider requesting the consultations.

7. Failure to follow these Rules and Regulations may result in a provider's referral to the Professional Quality and Peer Review Committee.

8. 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.

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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 ADVANCED PRACTICE 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.

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