Covenant Specialty Hospital

# MEDICAL STAFF RULES AND REGULATIONS

**December 5, 2006**

**Revised December 2, 2009**

**Revised March 15, 2011**

**Revised April 2, 2013**

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# I. PATIENT'S RIGHTS

The Medical Staff supports the rights of each patient in accordance with the policies and procedures of Covenant Specialty Hospital that guide the Hospital's interaction with the care of the patient. The Hospital's policies and procedures describe the mechanisms or processes established to support the following patient rights:

**a)** Become informed of his/her rights as a patient in advance of, or to receive this information should he or she so desire.

**b)** Exercise these rights without regard to race, color, national origin, disability, age, gender, sexual orientation, cultural, economic, educational or religious background or the source of payment for care.

**c)** Considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment.

**d)** Appropriate assessment and management of pain.

**e)** Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff. All patients have the right to be free from physical or mental abuse, and corporal punishment.

**f)** Knowledge of the name of the physician who has primary responsibility for coordinating the patient's care and the names and professional relationships of other physicians and healthcare providers who will see the patient.

**g)** Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.

**h)** Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

**i)** Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or

refuse treatment.

**j)** Formulate advance directives regarding his or her healthcare, and Hospital staff and practitioners who provide care in the Hospital comply with these directives (to the extent provided by state laws and regulations).

**k)** Have a family member or representative of his or her choice notified promptly of his or her admission to the Hospital.

**l)** Have his or her personal physician notified promptly of his or her admission to the Hospital.

**m)** Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.

**n)** Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the Hospital. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.

**o)** Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of request).

**p)** Reasonable responses to any reasonable request he/she may make for service.

**q)** Leave the Hospital even against the advice of his/her physician.

**r)** Reasonable continuity of care.

**s)** Be advised of the Hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the Hospital contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.

**t)** Be advised if Hospital/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

**u)** Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the hospital.

**v)** Examine and receive an explanation of his/her bill regardless of source of payment.

**w)** Know which Hospital rules and policies apply to his/her conduct while a patient.

**x)** Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

**y)** To be included in experimental research only if you give informed, written consent. You have the right to refuse to participate.

**z)** To obtain a copy of your medical records at a reasonable fee and within 30 days after submitting a written request to the hospital.

**aa)** To exercise your constitutional, civil and legal rights.

# II. ADMISSION AND REGISTRATION OF THE PATIENT

## a) Admission

i) Length Of Stay – The hospital shall accept patients with an expected length of stay of 14 – 30 days (aggregate 25 days) who need restorative care and/or have potential for meeting specific goals. Any diagnosis may be appropriate if the patient's needs meet admission criteria.

ii) General Consent Form At Time Of Admission - A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission.

iii) No Admission Without Provisional Diagnosis Except In Emergencies - Except in the case of emergency admission, 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 treatment shall be recorded as soon as possible. A copy of the Emergency Service record shall accompany the patient to the nursing unit.

## b) Medical Records

i) Patient's Medical Record - Each attending physician will be responsible for the preparation of a complete and legible medical record for each patient, as required by state and federal laws and regulations, and the Joint Commission on the Accreditation of Healthcare Organizations.

ii) Content Of The Medical Record

(1) The content of 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 healthcare providers.

(2) Each medical record shall contain at least the following:

(a) The patient's name, address, date of birth, and the name of any legally authorized representative.

(b) The date and time of admission and discharge.

(c) The patient's legal status for patients receiving mental health services.

(d) Emergency care provided to the patient prior to arrival, if any.

(e) The record and findings of the patient's assessment, including the initial screening for appropriateness for LTACH admission.

(f) A statement of the conclusions or impressions drawn from the medical history and physical examination.

(g) A validation within 48 hours of admission that the patient meets

admission criteria for LTACH, as well as regular evaluations for continued stay.

(h) The diagnosis or diagnostic impression.
(i) The reason(s) for admission or treatment.
(j) The goals of treatment and the treatment plan.
(k) Evidence of known advance directives.
(l) Evidence of informed consent for procedures and treatments for which informed consent are required by organizational policy.
(m) Diagnostic and therapeutic orders, if any.
(n) All diagnostic and therapeutic procedures and tests performed and the results.
(o) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate.
(p) Progress notes made by the medical staff and other authorized individuals.
(q) All reassessments and any revisions of the treatment plan.
(r) In cases of restraint or seclusion:
    (i) All restraints require physician orders and must be authenticated per policy.
(s) Clinical observations and nurses' notes.
(t) The patient's response to care provided, including any complications or hospital-acquired infections
(u) Consultation reports.
(v) Every medication ordered or prescribed for an inpatient.
(w) Every dose of medication administered and any adverse drug reaction
(x) Anesthesia records
(y) Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge.
(z) All relevant diagnoses established during the course of care.
(aa) Any referrals/communications made to external or internal care providers and to community agencies.
(bb) Conclusions and final diagnosis at termination of hospitalization.
(cc) Discharge instructions to the patient/family.
(dd) Autopsy report, when performed.
(ee) Clinical resume or final progress note.
    (i) Clinical resume summarizes reason for hospitalization, significant findings, procedures performed and treatment rendered patient's condition at discharge, and any specific instruction given to the patient and/or family as pertinent.
    (ii) A final progress note may be substituted for the clinical resume on those patients who require less than a 48-hour period of hospitalization. The final/discharge progress note documents the patient's condition at discharge, discharge

instructions and follow-up care requirements.

(3) Emergency care records; the following additional information is required in the medical record:
   (a) Time and means of arrival.
   (b) The patient's leaving against medical advice.
   (c) Conclusion at termination of treatment, including final disposition, patient's condition at discharge, and any instructions for follow-up care.

iii) Medical Record Review Committee - The Medical Record Review Committee of the Medical staff will meet quarterly and will review a random sample of medical records for timely completion and clinical pertinence. Findings from the reviews will be presented to the clinical components quarterly at the next scheduled meetings. The committee shall also be responsible for approval of all forms to be used in the medical record.

iv) Delinquent Medical Records - All physicians are responsible for completing their medical records within 30 days of a patient's discharge. Failure to complete incomplete records by the suspension date will result in the record becoming delinquent and the physician will be suspended of any and all privileges including admitting, consults, etc.

Three (3) thirty-day suspensions in one calendar year will result in referral to the Executive Committee for review.

v) History and Physical - The History and Physical (H & P) update must be performed within 24 hours of the inpatient admission, or a physician may utilize an H & P that was performed up to 30 days prior to the inpatient admission. However, when using an H & P that was performed before admission, an update is required within 24 hours of inpatient admission. The entire H & P (including any applicable update) must be performed and documented and in the record within 24 hours, including the update to a previously performed H & P.

The update must include a physical assessment of the patient to update any components of the patient's current medical status that may have changed since the prior H & P, or to address any areas where more current data is needed, confirming that the necessity for the procedure or care is still present and that the H & P is still current. Even if the patient's condition has not deviated from the H & P, an update must still be completed within 24 hours of inpatient admission in order to comply with current regulations. All history and physicals shall be authenticated.

   (a) Deficiency Letter will be sent if the H&P is not completed in the

first 24 hours of a patient's admission

(b) If the H&P is not completed the physician will be suspended until the H&P is complete

vi) Consultation Reports - Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examinations of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When procedures are involved, the consultation note shall, except in emergency situations so verified by the record, be recorded prior to the procedure.

vii) Discharge Summaries - A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over 48 hours. The summary concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, the final diagnoses, and any specific instructions given to the patient or family including physical activity, medication, diet and follow-up. Progress note may be substituted for the resume. The final progress note should include condition at discharge instructions given to the patient and/or family relating to physical activity, medication, diet and follow-up care required. All summaries shall be authenticated by the responsible staff member.

viii) Progress Notes

(1) An admission progress note, handwritten by the admitting physician is required within 24 hours of admission and should contain sufficient information to justify admission and guide the nursing personnel and other physicians in caring for the patient until the complete, dictated history and physical is available on the chart.

(2) Progress notes must be written daily by either the attending or consulting physician to provide a chronological record of the patient's progress. Progress notes shall be written at the time of observation, and shall be dated and signed by the physician at the time the note is entered. The progress notes shall be entered in chronological order.

(3) Progress notes shall be written describing new symptoms arising, changes in the condition of the patient, complicating factors in the course of the disease, indications for continued hospitalization, and reactions to medications or procedures.

(4) Each time a new or revised diagnosis is made, it shall be recorded into the progress notes as soon as possible.

(5) A complete detailed progress note on all special procedures, such as spinal puncture, thoracentesis, biopsies, etc., shall be written

immediately after the procedure is completed. Pertinent laboratory and radiological findings and results of any specific examination shall be recorded.

(6) Any employee or individual who treats, counsels, educates, tests, evaluates or ministers to a patient may document in the patients' medical record as delineated in their job description. Documentation shall be in accordance with generally accepted professional standards of documentation and as required by the Medical Staff Rules and Regulations, hospital policies and regulatory and accrediting bodies.

(7) In the case of the death of a patient, the date, time and circumstances of death must be recorded by the physician or registered nurse pronouncing the death.

ix) Content Of Discharge Records - To provide important information concisely to the medical record's other users and to facilitate continuity of care, the following discharge documents are required:

(1) At discharge from inpatient care, a clinical resume concisely summarizes the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the patient's condition, and any specific instructions given to the patient and/or family, as pertinent.

(2) A final progress note is substituted for the resume only for those patients who require less than a 48-hour period of hospitalization.

x) Conditions Of Discharge Records

(1) All significant clinical information pertaining to a patient is entered into the medical record as soon as possible after its occurrence.

(2) The medical record is complete when:

(a) An order has been written by the attending practitioner or his designee discharging the patient;

(b) Its contents reflect the diagnosis, diagnostic test results, therapy, patient's condition and in-hospital progress, and patient's condition at discharge;

(c) Its contents, including any required clinical resume or final progress notes, are assembled and authenticated, and all final diagnoses and any complications are recorded without the use of symbols or abbreviations; and,

(d) If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, the patient shall sign an "Against Medical Advice" (AMA) form. In the event the patient refuses to sign such a form, a note to this effect along with the signatures of two witnesses will be entered into the AMA form.

(3) Time Frame - All inpatient medical records of discharged patients must be completed, signed and ready for filing thirty days (30 days)

after the patient is discharged. Practitioner-specific information - In conjunction with the above time frame:

(a) Bi-weekly – A staff appointee who does not comply with this regulation will receive a letter from the Medical Records Department at the end of the second week following patient discharge. The Health Information Management Department will send a letter to each Medical Staff appointee who has not completed and signed an inpatient medical record on a discharge patient of seven (7) days or more. This letter will serve as a warning to the Medical Staff appointee.

(b) Fifteen (15) Days - After fifteen (15) days following discharge, if the record has not been completed and signed, the Medical Staff appointee's office will be notified by phone that he/she will be temporarily suspended from the Medical Staff by the Chief of Staff or the Chief Executive Officer at the end of the thirty (30) days, effective at 6:00 a.m. the next morning.

(c) The Director of Health Information Management, or his designee, shall inform the Admitting Office, the Medical Staff Coordinator, the Administration Office and appropriate clinical components.

(d) Justifiable reasons for delay in completion - The Chief of Staff, or in his absence, the Chief of Staff Elect, or applicable Committee Chairman shall have the power to excuse a Medical Staff appointee from delinquent status.

(e) Conditions of suspension - All the practitioner's privileges are suspended except for continuing care of patients already in the Hospital. The practitioner's privileges will remain suspended until all delinquent in patient records are completed. Suspension includes suspension of the privilege to admit patients including elective and emergency patients. Previously scheduled procedures are allowed. All future scheduling (past 6:00 a.m. deadline) is not allowed.

(f) Reinstatement of privileges - Reinstatement of privileges shall be automatic upon the completion of delinquent inpatient records. The Director of Health Information Management, or designee, shall inform the Admitting Office, the Medical Staff Coordinator, the Administration Office and appropriate clinical components. In the event of a crisis situation, temporary privileges may be granted by the Hospital Administrator or the Chief of Staff.

(4) Continual monitoring - The Medical Record Review Committee shall be responsible for analyzing suspension trends for the purpose of administering this rule. One suspension of staff privileges for a period of over 30 days, or three suspensions of staff privileges within any 12-month period shall be sufficient cause for disciplinary action by the Medical Executive Committee. A monthly

report will be presented to the Medical Executive Committee.

xi) Re-Admissions - In the case of readmission of a patient, all previous records shall be available for use by the attending practitioner, whether or not he was the original practitioner.

xii) Retirement Of Incomplete Records

(1) The medical records of those physicians who cannot complete their records due to death or relocation shall be retired only upon action of the Executive Committee of the Hospital Staff and shall result in the forfeiture of that physician's privileges. Privileges may be reinstated only upon completion of those records and reapplication to the staff.

(2) Permanent Filing of the Medical Record -A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee as a retired record.

(3) Record Retention - Everything but the current and prior year's charts shall be stored. This length of time for record retention was determined based on law and regulation, its use for patient care, legal, research, or educational purposes, and limited space. The Medical Records Department will provide adequate, ongoing training of personnel relating to retrieval of documents.

**c) Emergency Care Services**

i) Transfer of Patients - Due to the status and mission of the Hospital as a long term acute care hospital, a formal emergency department will not be available at the hospital. Patients in need of emergency services will be transferred from the Hospital, referred to the most accessible and appropriate acute care hospital wherein the patient shall then be treated according to the policy and procedure of the acute care hospital. Given the proximity of the Hospital to Covenant Hospital, the patient shall be transferred to Covenant Hospital, in keeping with the defined transfer agreement or another appropriate facility for emergency services unless another acute care hospital is so indicated by the needs, condition and preference of the patient, family and attending physician. The Hospital's procedures for patient transfers to other facilities will be followed.

ii) Emergency Patient Transfers - Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility when, in the judgment of the attending practitioner or designee the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.

iii) Emergency Medical Treatment and Active Labor Act (EMTALA) – In no way shall this policy of the Hospital be in conflict with federal or state requirements and regulations governing the transfer of patients from one hospital to another as stipulated by intent and language of EMTALA.

**d) Practitioner-Specific Information**

i) Who Can Admit And Treat Patients - Only individuals granted Medical Staff appointment and clinical privileges may admit patients to this Hospital except as provided in the Medical Staff Bylaws and Rules and Regulations. These privileges are granted in accordance with state law and criteria for standards of medical care established by the Medical Staff. Only individuals granted clinical privileges may treat patients at this Hospital.

ii) Responsibility Of Admitting Practitioner - A physician appointee or appointee of the Active Medical Staff shall be responsible for the medical care of each patient in the Hospital. The attending practitioner shall be responsible for necessary special instruction and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure that the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service concerned in the treatment of the disease, which necessitated admission. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel who are a source of danger from any cause whatsoever. Information should be provided to assure the protection of the patient from self-harm, if necessary.

iii) Communicable Diseases – Physicians are obligated to report all "Reportable Communicable Diseases" to Public Health authorities. When a communicable disease is suspected or confirmed, isolation precautions should be ordered and maintained.

iv) Physician's In Group Practices – The Medical Staff recognizes that physicians in group practices or associations may authorize partners/associates to co-sign, start, continue, or terminate the patient's diagnostic/therapeutic treatment, and make entries in the medical record, so long as those individuals are credentialed members

of the medical staff of the Hospital.

## III. ASSESSMENTS OF THE PATIENT

### A) Content and Conditions of History and Physical

a) A patient admitted for inpatient/outpatient services has a medical history taken and an appropriate physical examination performed by a physician or who has such privileges. The History and Physical shall include the following:

(1) Physical, Psychological - There is an initial assessment/screening of each patient's physical, psychological, and social status to determine the need for care or treatment, the type of care or treatment to be provided, and the need for any further assessment.

(2) Scope/Intensity Of Further Assessment - The scope and intensity of any further assessment are determined by the patient's diagnosis, treatment setting, patient's desire for treatment, and patient's response to any previous treatment.

(3) Nutritional Status - The need for assessing the patient's nutritional status is determined through a nutritional assessment from initial screening for determination of moderate or high nutritional risk.

(4) Functional Status - The patient's functional status is determined by a functional assessment, which is performed for each patient where appropriate.

(5) Allergies/Drug Idiosyncrasies – Assessment of the patient's known allergies or drug idiosyncrasies.

(6) Time Frames - The initial assessment of each patient admitted is conducted within a time frame preceding or following admission as follows:

(i) Medical Admission - The history and physical must be within the first 24 hours of admission as an inpatient or no more than seven days prior to admission as an inpatient. This time frame applies for weekday, weekend, and holiday admissions.

## B) Diagnostic Testing

a) Diagnostic testing is performed, including laboratory and other invasive and non-invasive diagnostic and imaging procedures, relevant to the determination of the patient's health care or treatment needs and to the actual care or treatment of the patient.

i) Tests With Clinical Interpretation - When the report of test results is to include clinical interpretation, adequate clinical information is provided with the request for the test.
ii) Alleged Or Suspected Abuse And/Or Neglect Assessment - Documentation in the patient's medical record shall be consistent with the Hospital's policy.

## C) Consultations

a) Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his or her area of expertise. Opinions requiring medical judgment are written or authenticated only by Medical Staff appointees and other individuals who have been granted clinical privileges, or by house staff residents under the supervision of an Active staff member who has staff privileges. Unless physician-to-physician contact has been made, or otherwise ordered, the nurse shall notify the consulting physician of the request.

(1) Content - Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

(2) Conditions - It is the duty of the Medical Staff, and the Medical Executive Committee, to see that appointees of the Medical Staff do not fail in the matter of calling consultants as needed, and in all cases, as soon as possible. Judgment as to the serious nature of the illness and questions of doubt as to diagnosis and treatments rests with the practitioner responsible for the care of the patient. Circumstances under which consultations may be sought by the Medical Staff throughout the Hospital include the following:
(i) Cases of serious illness in which the diagnosis is obscure;
(ii) Cases in which there is doubt as to the best therapeutic

measures to be utilized;

(iii) Cases in which, according to the judgment of the practitioner, the patient is not a good medical or surgical risk;

(iv) Cases requiring clinical judgment/treatment outside of the attending practitioner's credentialed specialty/sub-specialty and/or clinical privileges.

(v) The Medical Staff shall give due consideration to the need for psychiatric consultations in patients with the following disorders, which are not all-inclusive:

a. Suicide attempts
b. Acute depression
c. Situational depression
d. Alcohol or drug dependency
e. Acute alcoholism
f. Anxiety disorders

(3) Request Form For Radiology/Pathology - Consultation request forms for radiology and pathology shall be filled out completely. The attending practitioner is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes by a nurse.

(4) Time Frame - The Medical Staff Consultant shall see the patient, and the consultation shall be dictated or written, each written within two (2) working days of the ordered consult.

## IV. TREATMENT OF THE PATIENT

The Hospital shall have at all times a doctor of medicine or doctor of osteopathy available for patient care on duty or on call.

Care for each patient shall be under the direction of a doctor of medicine or osteopathy who shall be responsible for any medical or psychiatric problem that is present on admission or develops during hospitalization and is not specifically within the scope of practice of a doctor of dental medicine, podiatric medicine or chiropractor.

**A) Care Or Treatment Decisions**

The information generated through the analysis of assessment data is integrated to identify and prioritize the patient's needs for care or treatment. These decisions are based on the identified patient needs and on care or treatment priorities. It is the duty of the Medical Staff to inform the patient or the appropriate family member of the patient's medical condition, including diagnosis/ prognosis, and any risk or

complications associated with medical or surgical procedures the patient will undergo.

**B) Selecting Appropriate Procedures**

The Medical Staff defines the scope of an appropriate assessment for emergent and non-emergent invasive procedures in accordance with "Assessment of Patients" (see Section III). Through the assessment process, the optimal time for the procedure(s), safe performance of the procedure(s), and provision of a baseline for interpreting findings while monitoring the patient will be established. Assessment provides the information needed to choose the appropriate procedure for the patient:

a) Medical, anesthetic, and drug history;
b) Physical status;
c) Diagnostic data;
d) Risks/benefits of the procedure(s); and
e) The need to administer blood or blood components.

**C) Use of Special Treatment Procedures**

Special justification must be documented in the patient medical record for the use of special treatment procedures as follows:

a) Restraints -It is the policy of the Long Term Acute Care Hospital to ensure that the written policies and procedures regarding restraints are followed. Restraints shall only be used under the following conditions:
   i) Upon written order of a physician or other person lawfully authorized to prescribe care;
   ii) When less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm;
   iii) The type/technique must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm;
   iv) The order must specify the duration and circumstances under which the restraints are to be used;
   v) The orders must be specific to individual patients;
   vi) There shall be no standing orders; and
   vii) There shall be no P.R.N. orders for physical restraints.
   viii) The restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order

   Adequate appropriate clinical justification must be documented in the patient medical record for the use of safety restraints under the aforementioned conditions.

b) Restraints Used For The Management Of Violent Or Self-Destructive Behavior – Restraints for behavior control shall only be used subject to the following conditions:
   i) On the signed order of a physician or other person lawfully authorized to prescribe care, except in an emergency which threatens to bring immediate injury to the patient or others. In such an emergency, an order may be received by telephone, and shall be authenticated within twenty-four (24) hours. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record;
   ii) With a written order designed to lead to a less restrictive way of managing, and ultimately to the elimination of behavior for which the restraint is applied;
   iii) That each patient care plan which includes the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method;
   iv) That patients shall be restrained only in an area that is under supervision of staff and shall be afforded protection from other patients who may be in the area;
   v) That each order is limited up to 4 hours for adults 18 years of age or older, 2 hours for children and adolescents 9 to 17 years of age, or 1 hour for children under 9 years of age.
   vi) That physicians, independent licensed practitioners, or registered nurses must physically assess the patient within one hour of the initiation of the restraint or seclusion. The original order may be renewed, but must not extend past a 24-hour period;
   vii) This one (1) hour face-to-face evaluation must include: 1) The patient's immediate situation, 2) the patient's reaction to the intervention, 3) the patient's medical and behavioral condition; and 4) the need to continue or terminate the restraint or seclusion;
   viii) If face-to-face evaluation is conducted by a trained RN, that staff member must consult the attending physician or other licensed independent practitioner as soon as possible after the completion of the 1-hour face-to-face evaluation; and
   ix) A new order may be issued only after an attending physician sees and assesses the patient.

c) Postural Supports – Postural supports may only be used to improve a patient's mobility and independent functioning, to prevent a patient from falling out of a bed or a chair, or for positioning, rather than to restrict movement. These methods shall not be considered

restraints. The use of postural supports and the method of application shall be specified in the patient's care plan and approved in writing by the physician or other person lawfully authorized to provide care. Postural supports shall be applied under the supervision of a licensed nurse and in accordance with the principles of good body alignment and with concern for circulation and allowance for change of position.

**D) Informed Consent**

a) Patients shall have the right to be involved in health care decisions, in collaboration with a physician;
b) To the extent permitted by law, a patient has a right to accept or reject medical care; and
c) Patients have the right to access information necessary to enable the patient to make informed treatment decisions. This information shall be presented in a format which the patient can understand; e.g. in their language if they do not speak English, sign language for the deaf, or other appropriate methods.
d) Physician Responsibility - The physician is responsible, in accordance with Texas Statutes to obtain the informed consent of their patient prior to any invasive medical or surgical procedure. The process to be followed is set forth in the Informed Consent Policy.

   The invasive medical or surgical procedure shall not occur until an informed consent signed by the patient or healthcare surrogate/proxy, when appropriate, is included in the patient's medical record. In an emergency and in the absence of an informed consent, the treating physician is responsible to document the patient's diagnosis, the proposed treatment and the medical necessity of the treatment.

**E) Orders**

a) Preprinted Orders - A practitioner's pre-printed orders shall be included as a part of the medical record, timed, dated, and signed by the practitioner. All pre-printed physicians' orders shall be printed on the Hospital's "Physicians' Orders" forms. Implementing and maintaining this policy shall be the responsibility of each department/service of the Hospital.
   i) The words "routine" or "standing" shall not appear on the heading on the "Physicians' Orders" sheet.
   ii) Another statement shall be added to the top of the "Physicians' Orders" sheet stating that "ONLY THOSE NUMBERED ORDERS LISTED WHICH ARE CIRCLED WILL BE CARRIED OUT". The orders shall be TIMED, DATED, and SIGNED (a line should be typed with "Physicians' Signature" typed underneath) each time they are requested for use.

iii) Physicians shall submit their orders to the applicable Hospital department, service or unit to be printed on the Hospital's "Physicians' Orders" forms.
iv) Review and revision dates and records will be maintained by the applicable Hospital department, service or unit and the physicians notified accordingly by the applicable one prior to expiration of individual orders.
v) All of the "Physicians' Orders" shall be reviewed, evaluated and modified as needed by the applicable Hospital department, service or unit, and at least every two years.

b) Conditions
i) All verbal orders are authenticated as soon as possible, with a goal of 48 hours.
ii) All previous orders are cancelled when patients enter a different level of care.
iii) The attending practitioner shall countersign all orders, the history and physical examination and pre-operative notes when they have been recorded by an intern, resident physician, medical student, physician's assistant or nurse practitioner.
iv) Orders for inpatient/outpatient services will only be accepted from Medical Doctors, Doctors of Osteopathy, Doctors of Podiatry, and Doctors of Dental Services.
v) Orders which are illegible or improperly written will not be carried out until verified and understood by the care giver.

c) Verbal Orders
i) Individuals receiving orders - Verbal orders of authorized individuals are accepted and transcribed by qualified personnel who are identified by title or category, listed as follows:
Non-medication orders
(1) Licensed Nurses
(2) Pharmacists
(3) Certified respiratory therapists or designees
(4) Registered physical therapists or designee
(5) Clinical dietitians
(6) Occupational therapists or designee
(7) Social workers
(8) Registered medical technologists or designee
(9) Registered radiological technicians or designee
ii) Verbal orders shall not be taken for chemotherapeutic agents.
iii) Verbal orders must be authenticated in accordance with state and federal law. Within 48 hours, Verbal orders must be timed, dated, signed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (limited to doctors of medicine or osteopathy, doctors of dental surgery,

or dental medicine, doctors of podiatric medicine, doctors of optometry, or chiropractors), and initiated by the prescribing practitioner as soon as possible.

iv) A signed order for outpatient tests and procedures is required. The scheduling of an outpatient test or procedure is not considered an order.

v) The hospital employee who takes the verbal order will flag the verbal order chart entry for the practitioner's signature.

vi) Verbal orders for restraints/seclusion and advance directives/DNR are permitted but they must be signed as per hospital policy.

Note: Designee is determined by the applicable departmental medical director.

d) Medication Orders - may be accepted and transcribed by:
   i) Licensed nurses
   ii) Pharmacists

e) Transfusion Services Orders - Must be received in writing by registered or licensed nursing personnel.

f) Individuals Dictating Orders - all verbal orders are dictated by the practitioner or his credentialed designee.

g) Individuals Signing Orders - The attending practitioner shall countersign all orders and medical record entries when they have been recorded by house Staff and non-physicians.

h) Automatic Stop Order
   i) There shall be an automatic stop order on all narcotics, antibiotics, steroids, anticoagulants, barbiturates, and tranquilizers after 45 days unless the exact number of doses or treatment have been clearly specified by the physician.
      (1) Ketorlac shall have a stop date of 5 days unless the exact number of doses or treatment have been clearly specified by the physician.
   ii) There shall be an automatic release after 48 hours for blood ordered on a standby basis unless the attending physician requests an extension of time.

i) Symbols and Abbreviations - Symbols and abbreviations shall have only one meaning. Symbols and abbreviations may be used in the body of the medical record and may be used only when they have been approved by the Medical Record Committee and Medical Executive Committee. Final diagnosis or procedures shall be

recorded without the use of symbols or abbreviations.

j) Final Diagnoses - Final Diagnoses shall be recorded in full on all patients, without the use of symbols or abbreviations, on the discharge summary or face sheet, and shall be timed, dated, and signed by the responsible practitioner at the time of discharge.

k) Release Of Medical Information - All medical records are the property of the hospital, and shall be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order subpoena, or statue. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committees.

# V. REASSESSMENT OF THE PATIENT

## A) Patient's Status

The patient's status is periodically reviewed so care decisions remain appropriate. The reassessment process is ongoing throughout the patient's contact with the Hospital and is triggered at key decision points as well as at any intervals specified by the Hospital. The patient should be reassessed daily by the attending physician or his designee, or when clinically indicated.

# VI. ALLIED HEALTH PROFESSIONALS

## A) Definition

An Allied Health Professional (AHP) is an individual, other than a licensed M.D., D.O., Dentist (D.D.S. or D.M.D.), or Podiatrist, who exercises clinical judgment in the area of their professional competency, who is qualified to provide patient care services within the scope of his/her license, registration and/or certification, and as delineated in his/her respective credentialing criteria.

a) Independent AHP - Independent AHP's consist of licensed professionals who may provide patient care services, within the scope of his/her license and consistent with the privileges granted. Independent AHP shall include but not be limited to Licensed Psychologists, Physician Assistants, Certified Registered Nurse Anesthetists, and Licensed Nurse Practitioner. Independent AHP's are non-voting members of the Medical Staff, in the Category of Allied Health Professional. AHP's may not hold elected Medical

Staff office. An independent AHP shall:

(1) Exercise independent judgment within the scope of his/her license, provided that a physician member of the Medical Staff shall have the ultimate responsibility for the patient's medical care;
(2) Participate directly in the management and care of patients under the general supervision or direction of a Medical Staff member, with the exception of Psychologists who may practice without supervision or direction of a Medical Staff Member;
(3) Record reports and progress notes on the patient records; and
(4) Not admit or discharge patients.

b) Dependent AHP - consist of licensed professionals who do not practice independently, but who practice their profession within the scope of their license at the direction of a sponsoring physician. Dependent AHP's shall include but not be limited to Physician Assistants, Advanced Registered Nurse Practitioners, and R.N. First Assistants.

**B) Appointment/Reappointment/Clinical Privileges of AHP**

a) Nature
Dependent AHP's consist of licensed professionals who do not practice independently, but who practice their profession within the scope of their license at the direction of a sponsoring physician. Dependent AHP's shall include but not be limited to Physician Assistants, Advanced Registered Nurse Practitioners, R.N. First Assistants.

Membership on the AHP Staff is a privilege which shall be extended only to those professionally competent licensed AHP's who continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws of the Hospital.

b) Privileges
Whenever the term "privileges" is used in this Section, it shall be defined as and be deemed permission to perform those specific functions and activities granted, and shall not encompass those privileges as granted to physician members of the Medical Staff.

c) Application and Appointment
AHP's shall be subject to the same appointment and reappointment process as are all physician members of the Medical Staff as

specified and set forth in the Medical Staff Bylaws. An individual applying for privileges must be recommended by the Credentials Committee, recommended by the Medical Executive Committee and approved by the Board of Directors of the Hospital.

d) Corrective Action
   (1) Independent AHP's shall be subject to and shall be afforded the same procedures regarding investigations and suspensions as are physician members of the Medical Staff as set forth in the Medical Staff Bylaws.
   (2) Dependent AHP's shall be subject to the same procedures governing investigations and suspensions as set forth in the Medical Staff Bylaws.
   (3) The clinical duties and responsibilities of dependent AHP's shall terminate if the Medical Staff appointment of their Medical Staff sponsor is terminated for any reason, or clinical privileges are curtailed to the extent that the professional services of the dependent AHP are no longer necessary or permissible to assist the Medical Staff sponsor.

**C) AHP Responsibilities**

Each AHP shall:

i) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient for whom they are providing services, subject to the direction of the physician member attending the patient;

ii) Participate as appropriate in performance improvement activities, and in discharging such other functions as may be required, including but not limited to compliance with the timely completion of medical records; and

iii) Comply with all applicable Medical Staff Bylaws, Rules and Regulations and Policies of the Hospital.

**D) Sponsoring Physician Responsibilities**

Each sponsoring physician shall:

i) Be a member in good standing on the Medical Staff of the Hospital;

ii) Notify the Medical Staff office within 24 hours of the termination or withdrawal of sponsorship of any AHP;

iii) Accept full responsibility for all medical decisions and interventions rendered by the AHP; and

iv) Assure the compliance by the AHP of their insurance obligations as set forth below.

### E) Insurance

Each AHP shall provide proof of professional liability insurance with limits of not less than $250,000 per claim / $750,000 aggregate with a company licensed to issue insurance in the State of Texas before they can exercise any privileges granted.

### F) Hospital-Employed AHP

AHP's who are employed by the Hospital are subject to the requirements and regulations of their employment and are not subject to the Medical Staff Bylaws and Rules and Regulations. Hospital-employed AHP's undergo an equivalent review process at the time of application for employment and are regularly reviewed in the Hospital's performance appraisal process. Hospital-employed AHP's are entitled to the Hospital's Conflict Resolution Process.

## VII. MISCELLANEOUS

### A) Preparing Patient for Procedures

a) <u>Risks/Benefits Associated With the Procedure(s)</u>
   i) Consent - Before obtaining the patient's consent, risks and benefits and any alternative options associated with the planned procedure(s), are discussed with the patient. As appropriate, the patient's medical record includes documentation of discussion regarding alternative options if they exist, the need for and risks involved with blood transfusions and available alternatives, and any anesthesia options with attendant risks.
   ii) Conditions - When discussion about risks, benefits and options between the patient and the practitioner occur before admission to the Hospital, the patient's medical record reflects that information in either the admission note or in informed consent documentation.

When discussion about risks, benefits and options between the patient and the practitioner occur after admission to the Hospital, the practitioner documents the discussion in the patient's medical

record.

**B) Impending Death or Death**

The Medical Staff will abide by federal and state regulations regarding organ/tissue donations.

The Medical Staff shall attempt to secure permission for autopsy in the following situations:

Each member of the staff should make an attempt to secure autopsies in all cases of unusual deaths and of medical, legal, and educational interests, or in those cases where an autopsy is required by law; i.e., Coroner's Cases. No autopsy shall be performed without legal permit. Generally, autopsies shall be performed by the hospital pathologist or a qualified pathologist approved by the hospital pathologist, except in Coroner's Cases, where the Coroner or his deputy and appropriate law enforcement agency shall be notified, and which shall report to the scene within a reasonable period of time.

a) Requesting an Autopsy -The following are indications for autopsies performed at the request of a medical staff member:
   i) Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same.
   ii) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
   iii) Deaths in which the patient sustained or apparently sustain an injury while hospitalized that may have contributed to the patient's death.
   iv) Deaths at any age in which organs are donated and it is believed that an autopsy would disclose a known or suspected illness which may have a bearing on survivors or recipients of the transplant organs.
   v) Deaths known or suspected to have resulted from environmental or occupational hazards.

   If any of the above indications exist and an autopsy cannot be performed, the reason should be documented in the medical record.

b) Documentation of Request - When attempting to secure permission for autopsies, the physician shall document the following information in the patient's medical record:
   i) Party requesting the autopsy

ii) Response received to request for autopsy
iii) Other pertinent information deemed applicable

Said documentation shall be recorded in the Physicians' Orders or Progress Notes of the patient's medical record.

c) Consent – No autopsies shall be performed without the consent of the next of kin or the legally authorized agent. Hospital personnel shall notify the attending physician of any impending autopsy.

d) Transportation Of Corpse – The corpse shall be transported to the designated hospital as requested by the next of kin or the legally authorized agent.

e) Performance Of Autopsy – All autopsies shall be performed by the Hospital pathologist or by a physician to whom this responsibility has been properly designated. The individual performing the autopsy will notify the attending physicians when an autopsy is being performed.

f) Reporting To The Coroner – The Hospital shall report the following deaths to the Coroner:
   i) When the death of a human being appears to be caused by homicide or violence;
   ii) When the death of a human being appears to be the result of suicide;
   iii) When the death of a human being appears to be the result of the presence of drugs or poisons in the body;
   iv) When the death of a human being appears to be the result of a motor vehicle accident and the operator of the motor vehicle left the scene of the accident;
   v) When the death of a human being occurs in a motor vehicle accident and when an external examination of the body does not reveal a lethal traumatic injury;
   vi) When the death of a human being appears to be the result of a fire or explosion;
   vii) When the death of a child appears to indicate child abuse prior to the death;
   viii) When the manner of death appears to be other than natural;
   ix) When the death of a human being appears to be the result of drowning;
   x) When the death of an infant appears to be caused by sudden infant death syndrome in that the infant has no previous medical history to explain the death;
   xi) When the death of a human being occurs as a result of an accident;

xii) When the death of a human being occurs under the age of forty (40) and there is no past medical history to explain the death;
xiii) When the body is to be cremated and there is no past medical history to explain the death;
xiv) When the death of a human being is sudden and unexplained.

Autopsy reports shall be filed in the patient's record upon receipt.

g) Death Reporting in cases of Restraint or Seclusion
   i) The Hospital shall report deaths associate with the use of seclusion or restraint.
   ii) The Hospital must report the following to CMS:
      (1) Each death that occurs while a patient is in restraint or seclusion;
      (2) Each death known to the hospital that occurs within one (1) week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation;
      (3) Each death referenced in this paragraph must be reported to CMS by telephone no later the close of business the next day following knowledge of the patient's death.
   iii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion must be kept in a log and available upon request.
   iv) Staff must document in the patient's medical record the date and time the death was reported to CMS.

**C) Policies And Procedures Of The Medical Staff Or Hospital** - Policies and procedures governing use of various facilities of the Hospital, when determined and published by authorized committees or the appropriate departments of the Medical Staff and approved by its Executive Committee and the Governing Board, shall be adhered to by all appointees of the Medical Staff. Appointees of the Medical Staff are responsible for remaining abreast of current directives. Policies and procedures referred to previously and elsewhere in these Rules and Regulations are to be found in the Policy and Procedure Manuals of the Hospital or the Medical Staff.

The Medical Staff Policy and Procedures Manual shall be reviewed annually, or minimum of two years, by the Executive Committee, or his assigned designee.

Any revisions shall be approved by the Executive Committee when appropriate, or when necessary, referred to the applicable Medical Staff Department(s) or Committee(s) with final approval granted by the Medical Executive Committee (and Governing Board if applicable).

**D) Use Of Investigational Drugs, Devices Or Procedures** - The use of investigational drugs, devices or procedures shall be under the supervision of the Institutional Review Board (IRB) of the Hospital, as outlined in its committee bylaws. Only IRB approved physician investigators will be allowed this use.

**E) Protocol For Reporting Practitioner-Patient Care Problems** - The below stated policy should be followed by all Hospital personnel, as well as Medical, House and allied health professional staff :

a) When there is a concern that requires Medical Staff attention, the Hospital employee should first check with the attending physician.
b) If the attending physician is not available, or is unresponsive, the Hospital employee should contact the Nursing Supervisor, who in turn should contact the Administrator On-Call, when applicable, and then again, the attending physician.
c) If the problem is not solved at this point, then the Chief of Staff should be contacted by the appropriate “administrative” employee.
d) Medical Staff appointees should be aware of and honor this same line of protocol at their level of entry.
e) The only exception to this protocol would be problems involving infection control in which the Infection Control Committee has authority to act.

**F) Disaster Plan**

a) <u>Establishment of Disaster Plan</u> - 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.

b) <u>Medical Staff Section of Disaster Plan</u> - The Medical Staff section of the disaster plan should make provision for:
   i) Unified medical command under the direction of the Chief of Staff or his or her designated substitute;
   ii) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered to the facility most appropriate for administering definitive care;
   iii) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy.

c) <u>Practitioner Assignments</u> - All practitioners may be assigned to posts, and it is their responsibility to report their assigned stations.

The Chief of Staff in the Hospital and the Hospital Administrator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of Staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief Medical Officer and the Hospital Administrator. In their absence, the Vice Chief of Staff and an alternate in Administration are next in line of authority respectively.

d) Volunteer Practitioners – Volunteer practitioners will perform their assigned clinical duties under the direct supervision of an active staff member specializing in the same field as the volunteer practitioner. The clinical privileges assigned to each volunteer practitioner will not extend beyond the clinical privileges which they hold at another institution. Volunteer practitioners shall be required to provide the Credentials Committee, or other authorized personnel, with one of the following identification documents:

   i) A current picture hospital ID card;
   ii) A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency;
   iii) Identification that certifies that the practitioner is a member of a Disaster Medical Assistance Team (DMAT)
   iv) Identification that certifies that the practitioner has been granted authority, by a federal, state, or municipal entity, to render patient care, treatment, and services in a disaster circumstance.

   In the absence of such identification, a volunteer practitioner may be granted disaster privileges through the presentation by an active medical staff member with personal knowledge regarding the volunteer practitioner's pending approval by the hospital Administrator or Chief of Staff of the medical staff.

   Upon receipt of such identification, the Credentials Committee will begin the verification process of the volunteer practitioner by the same process as is required under the medical staff bylaws for granting temporary privileges to meet an important patient care need.

e) Disaster drills - The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill. The drills, which should be realistic, must involve the Medical Staff, as well as Administrative, Nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

## VIII. ADOPTION AND SIGNATURES

These Rules and Regulations, which are a part of the Medical Staff Bylaws of the Covenant Specialty Hospital, are adopted and made effective Tuesday, April 2, 2013**,** superseding and replacing any and all previous Medical Staff Rules and Regulations. Henceforth, all activities and actions of the Medical Staff and of each and every appointee to the Medical Staff shall be taken under and pursuant to the requirements of these Rules and Regulations.

**APPROVED BY THE MEDICAL STAFF ON TUESDAY, APRIL 2, 2013**

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Chief of Medical Staff

**APPROVED BY THE GOVERNING BOARD ON TUESDAY, APRIL 2, 2013**

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Chairman of Governing Board