

Sweeny Community Hospital Medical Staff

RULES & REGULATIONS

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SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS

- A. 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.
- B. 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 instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
- C. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.
- D. The admitting physician 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 might be a source of danger from any cause whatever.
- E. For the protection of patients and the medical and nursing staffs, acutely mentally ill or suicidal patients with medical conditions may be admitted only to stabilize their medical condition. Once the patient is medically stable, they shall be transferred to an appropriate facility. Potentially suicidal patients may be admitted to a private room only with an attendant. Mentally ill or suicidal patients without medical conditions will not be admitted, but will be transferred to an appropriate facility.
- F. The attending physician is required to document the need for continued hospitalization as required by the medical staff committee responsible for utilization review. Upon request of the committee, the attending physician must provide written justification of the necessity of continued hospitalization of any patient. This documentation must contain:
 - 1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
 - 2. The estimated period of time the patient will need to remain in the Hospital.
 - 3. Plans for post-hospital care.

This report must be submitted within forty-eight (48) hours of receipt of request. Failure to do so will initiate a Continued Stay Notice of Non-coverage to the patient and will be brought to the attention of the committee for action.

- G. Patients shall be discharged only upon order of the attending physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

- H. In the event of a hospital death more than twenty-four (24) hours after admission, the deceased shall be pronounced dead by the attending physician or according to Hospital policy regarding registered nurses pronouncing patients dead. Exceptions shall be made in those instances of incontrovertible or irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to the release of dead bodies shall conform to local law. See policy regarding Dead on Arrivals under Emergency Services for deaths under twenty-four (24) hours after admission.
- I. The attending physician or his/her alternate shall make an initial visit and assessment of the patient within twenty-four (24) hours of admission. Subsequent visits shall be conducted once each calendar day but are not to exceed thirty-six (36) hours from the last visit.

SECTION 2. MEDICAL RECORDS

- A. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note and autopsy report when performed.
- B. A complete admission history and physical examination shall be recorded within twenty-four (24) hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body, a plan of care and discharge plans. If a complete history has been recorded and a physical examination performed within thirty 30 days prior to the patient's admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the medical staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. To be acceptable, outside reports should be compatible with its current medical records system.
- C. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.
- D. Pertinent progress notes shall be recorded at the time of observation, at least once each calendar day, but not to exceed thirty-six (36) hours from the last visit, sufficient to permit continuity of care and transferability. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
- E. Operative reports shall include a detailed account of the findings at surgery as well as the

details of the surgical technique. Also noted in the operative report is blood loss and condition of patient. Operative reports shall be written (or dictated) immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. The operative report has to be completed before the patient transitions to another place of care and orders have to be re-written and reviewed. Any practitioner with undictated operative reports forty-eight (48) hours following the day of the operation shall be automatically suspended from operative privileges except for any inpatients who have already been scheduled for surgery.

- F. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, 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 operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.
- G. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
- H. Symbols and abbreviations may be used only when they have been approved by the medical staff. These will be reviewed on an annual basis. An official record of approved abbreviations shall be kept on file in the Medical Records Department.
- I. Final diagnosis shall be recorded within seven (7) days of discharge. If the final diagnosis has not been recorded within 7 days, medical records personnel are to call the attending practitioner for the diagnosis.
- J. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours except for certain selected patients with problems of minor nature. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.
- K. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- L. Records may be removed from the Hospitals jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the administrator. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the executive committee of the medical staff.
- M. Access to all medical records of all patients shall be afforded to members of the medical

staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the administrator, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

- N. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the appropriate committee.
- O. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.
- P. A patient's medical record shall be complete at the time of discharge, including progress notes, final diagnosis and (dictated) discharge summary. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the medical records department for fourteen (14) days after discharge. If the record still remains incomplete fourteen (14) days after all essential reports have been received and placed on the record, the administrator or the acting administrator shall notify the practitioner that his/her privileges to admit patients shall be suspended five (5) working days from the date of notice, and such practitioner shall remain suspended until the records have been completed. The director of medical records or his/her designee will call the practitioner forty-eight (48) hours in advance of his/her suspension. The admitting office and ER shall be notified if a practitioner is suspended. Three such suspensions of admitting privileges within any twelve (12) month period shall be sufficient cause for permanent suspension of privileges for that practitioner.
- Q. All verbal orders given by a medical professional must be recorded within 96 hours in the patient's medical record by the medical professional or another practitioner responsible for the patient's care.

SECTION 3. GENERAL CONDUCT OF CARE

- A. In addition to obtaining the patient's general consent to treatment, a specific informed consent that informs the patient of the nature of and risk inherent in any special treatment or surgical procedure shall be obtained in compliance with state law. The physician shall specify in his/her orders the exact procedures to be included on the informed consent form.
- B. Only "licensed" personnel, e.g., house staff, licensed nurses (R.N., L.V.N.), pharmacists, certified physiotherapists, respiratory therapists, and medical technologists, shall be authorized to accept verbal orders.
- C. The practitioner's order must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew", "repeat", and "continue" orders are not acceptable.
- D. All previous orders are canceled when patients go to surgery unless otherwise specifically ordered.

- E. All previous orders are canceled on transfer to the floor. They must be re-written as soon as seen by the practitioner.
- F. All drug and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service of AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

- 1. The Formulary exists to provide better patient care by assuring the patient of the highest quality of medication and the most economical operation of the Hospital pharmacy by preventing unnecessary duplication of medications, and thereby reducing the inventory and minimizing the loss of outdated and obsolete drugs.

The formulary will provide the staff with an up-to-date list of all medications, including the dosage forms and strengths, stocked in the Hospital pharmacy. When a specific brand of drug is prescribed by the physician, and that brand is in stock in the pharmacy, it will be dispensed. However, under this formulary system, a drug dispensed from the pharmacy may be of a different brand, but the contents will be the same basic drug as determined and accepted by the appropriate committee.

- 2. Medications brought to the Hospital by patients shall be identified and placed together in a bag. In the event that it is necessary to use the patient's own medications, this must be noted on the patient's chart, the doctor notified, and no charge shall be made for that medication.

- G. A qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise. All consultation reports must contain the documented opinion of the consultant based on an examination of the patient and his/her medical record(s). When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

Except in an emergency, consultation is required in the following:

Cases in which, according to the judgement of the physician,

- a. the patient is not a good medical or surgical risk,
- b. there is doubt as to diagnoses and the best therapeutic measures to be utilized.

The attending physician is primarily responsible for requesting consultation when indicated to assure competent care.

- H. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who in turn may refer the matter to the director of the

nursing service. If warranted, the director of nursing may bring the matter to the chief of staff or the vice-chief and he/she must also discuss the matter with the administrator. When circumstances are such as to justify such action, the chief of staff may himself/herself request a consultation.

- I. In the event a physician appears at the Hospital with the intention of directly or indirectly participating in patient care, and in the opinion of Hospital staff or a fellow physician, appears impaired in his capacity to do so, then:
1. The chief of staff or the designated active staff physician will be asked to come to the Hospital, meet with the physician then, and assess the situation.
 2. If in their opinion any question of impairment exists, a urine sample will be immediately obtained under direct supervision, and evaluated for presence of mood altering substances. A blood alcohol test may also be requested. If a medical problem is felt to be present, then appropriate evaluation will be recommended or requested. The impaired physician's spouse or other responsible adult will be contacted and transportation will be arranged to the physician's home or to a treatment facility.
 3. Should such urine or blood sample be positive for a mood altering substance, the matter will be brought before the Executive Committee of the Medical Staff. If mitigating circumstances are not clearly present, chemical dependency evaluation may be recommended and treatment considered.
 4. Failure of a physician to comply with requests for evaluation or noncompliance with committee recommendations for evaluation or treatment will result in disciplinary action.

J. Inpatient Emergencies

The Emergency physician on duty will respond to inpatient emergencies when the attending physician is not available and shall assume responsibility for the inpatient after the initial crisis until such time the attending physician is available.

K. Organized Health Care Arrangement

The typical relationship between the Hospital and the medical staff members who practice here is one of cooperation although they are separate entities. Sweeny Community Hospital District, its medical staff members engage in an organized health care arrangement. This arrangement allows participation in Hospital activities to deliver, monitor and improve care that is provided jointly.

SECTION 4. GENERAL RULES REGARDING SURGICAL CARE

A. Records

Required for every case that receives general anesthesia:

1. Surgical permit signed by the patient personally, if possible, or a legally responsible person (i.e., husband, wife, parent);

2. History and physical must be typed or hand written and on the record before the patient is given an anesthetic. If no history and physical is on the chart in an emergency surgery, the operating doctor is to inform the anesthesia department of the patient's condition.
3. All female patients who are of child-bearing potential (age 10 to 60) should have routine pregnancy determination prior to surgery if they have not been sterilized.

B. Surgery Performed by Limited Licensed Practitioners

A patient admitted for surgical care provided by a limited licensed practitioner is the dual responsibility of that limited licensed practitioner (dentist or podiatrist) and a physician member (M.D. or D.O.) of the medical staff.

1. The limited licensed practitioner's responsibilities -
 - a. A detailed history justifying hospital admission with regards to his/her field of training;
 - b. A detailed description of the examination of the pathology and diagnosis;
 - c. A complete operative report, describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.
 - d. Progress notes as are pertinent to the practitioner's care;
 - e. Discharge summary (or summary statement).
 2. Physician's responsibilities -
 - a. Medical history pertinent to the patient's general health.
 - b. A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - c. Supervision of the patient's general health status while hospitalized.
 - d. All surgery requires history and physical be done by an M. D. or D.O. member of the medical staff.
 3. The discharge of the patient shall be on written order of the admitting physician.
- C. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow-up of the patient's condition.
- D. The Medical Executive Committee or other appropriate committee shall determine through establishing a policy the surgical procedures requiring a qualified assistant present and scrubbed.
- E. All tissue or foreign material removed during an operation shall be sent to the Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

SECTION 5. EMERGENCY ROOM SERVICES

A. Statement of Purpose for the ED

1. To provide the highest quality of emergency medical care for patients presenting to the ED at Sweeny Community Hospital from all its surrounding regions.
2. To maintain standards of up to date professional medical care with the highest standards for patients presenting to the emergency department.
3. To initiate and maintain rules and regulations for effective government of the department.
4. To maintain an acceptable level of performance of all ED physicians through a comprehensive delineation of privileges and an on-going review and evaluation of the quality of care rendered by the department.

B. Physician Membership to the ED

1. All physicians are required to be board certified in Emergency Medicine, Internal Medicine, or Family practice.
2. All physicians are required to maintain certifications for licensing, DEA, ACLS, ATLS, PALS, and nine Trauma CME's per year.
3. All physicians shall be required to be approved by the Medical Executive Committee.
4. PA's and NP's shall be required to work under the supervision of a physician and be approved by the Medical Executive Committee.

C. Duties of the Departmental Physician

1. Physicians are required to be available for immediate services for any patient presenting to the ED and are expected to conduct themselves in such a way as to promote the best interest of the hospital.
2. Physicians are required to cover any medical emergencies occurring on the floor until the admitting attending responds or the patient is stabilized for continuing care or transfer.
3. ED physicians have the privilege and option of acting as a hospitalist to admit a patient to the hospitalist service. The patient admitted to the hospitalist service would be treated by the ED physicians unless transferred to another hospital or to an admitting attending's service.

4. ED physicians are required to write admitting orders under the direction of the admitting attending if requested to do so.
5. Any person presenting to the ED will receive a medical screening exam by a physician and all emergency conditions evaluated and treated or transferred.
6. ED physicians are required to make wet readings of plain x-rays in the ED if the radiologist's reading is not immediately available.
7. The sexual assault nurse examiner can perform a medical screen exam only in the event of a sexual assault case.
8. Radiology, laboratory, and respiratory personnel who are on call or duty 24 hours a day are expected to present to the ER in within 30 minutes. Any time there is a delay in personnel presenting to the ER in a timely manner, the ED physician will call the Administrator on call.
9. A registered nurse (RN) shall be on duty and present in the ED 24 hours per day.

D. Use and Function of the Emergency Department

1. The primary function of the ED is to treat any patient brought to the ED seeking treatment any hour of the day or night.
2. Until a time when the hospital shall have an ICU, when a patient becomes critical on the medical floor, the ER physician can transfer the floor patient to the ER for closer monitoring and critical care until a transfer can be completed.
3. There will be no elective surgery performed in the ED which requires general or regional anesthesia.
4. The ED may be utilized for inpatient treatment or procedure when other facilities are unavailable or inappropriate:
 - a. No emergency room record is to be made out on inpatient treated in the ED. An operative report will be filled out indicating patient's name, date, surgeon, anesthetic, and procedure done on the patient.
 - b. A nurse will assist the physician and will see that the ED is left properly cleaned and ready for another patient.

E. Specific Problems and Situation in the ED

1. In all instances, individual factors must be considered and the ED physician will determine the mode of treatment for each patient.
2. Nurse giving injection in the absence of the physician:
The nurse may give IM or IV injections as specified by the physician, to patients without a physician seeing the patient providing one of the following apply:
 - a. The patient has current legible prescription for the medication signed by a staff physician;
 - b. The patient's name, medication, and dosage are confirmed by telephone between the physician and the nurse;
 - c. The physician notifies the ED nurse prior to the patient's arrival the name of the patient, medication, and the dosage requested and the day this medication is to be given.
3. Dispensing oral medications:
Nurses are not allowed to dispense prescription or other medications to patients except when the entirety of the medication is consumed by the patient in the presence of the nurse. No medication is to be sent home with the patient unless the physician personally fills in the appropriate prescription label to accompany the medication.
4. Emergency Care given by nurse:
The ED nurse may initiate emergency lifesaving treatment until the physician arrives if he/she feels that such treatment is both indicated by the patient's condition and is justified by his/her training and experience.
5. Notifications of authorities:
 - a. The health officer is to be notified of persons having a reportable contagious disease.
 - b. The appropriate law enforcement agency will be notified of any reportable incident according to current state law. A policy will be developed and updated as needed delineating the type of cases which are reportable.
 - c. Blood alcohol and drug screen tests: The blood sample test for alcohol and drug screen, as well as the urine sample for drug screen, will be drawn at the request of the law enforcement officer or employer and the physician after the patient has given written consent. The law enforcement officer or employer will supply the consent form and may also provide the sample vial. Alcohol should not be used to prepare the skin prior to drawing of the blood sample.
6. Transfer of patients:
All transfers will follow Chapter 11. Rules Governing Hospital Patient Transfer Policies of The Texas Hospital Licensing Law, Article 4437f, Vernon's Texas Civil Statutes, guidelines, and procedures.
7. Patient refusing treatment:

If a patient comes to the ED and then refuses treatment or hospitalization as directed by the physician, he/she will be requested to sign a release before leaving the ED. If he/she refuses to sign a release, this should be recorded on the ED record.

F. Records and Reports

1. All patients presenting to the ED must be registered as an ED patient and a medical record created.
2. Instruction for follow-up care is to be given to the patient.
3. Records of the ED are reviewed in accordance with current policy to evaluate the quality of emergency medical care.
4. Physicians are required to complete their electronic charting within 12 hours of completing their shift.

G. Procedure in Case of Catastrophic Occurrence (Disaster)

1. The medical staff will establish procedures in the Hospital Disaster and Fire Plans with administration and Hospital personnel.

SECTION 6. INDICATIONS TO REQUEST AUTOPSY

The following are considered examiner or coroner cases (Justice of the Peace):

- a. A person who is killed or dies an unnatural death.
- b. When the circumstances of death are such as to lead to suspicion that death came by unlawful means.
- c. When a body is found and the circumstances of death are unknown.
- d. When a person commits suicide or when suicide is suspected.
- e. When a person dies who has been unattended by a physician.
- f. When a person dies who has been attended by a physician who is uncertain as the cause of death.
- g. An unexpected death within 24 hours after admission.

SECTION 7. MEDICAL STAFF MEETINGS

The annual meeting of the medical staff shall take place during January of each year. Notice regarding time and place shall be sent to each member of the staff at least three (3) days in advance of each meeting.

SECTION 8. SEVERABILITY

In the event that any clause or paragraph of these Bylaws, Rules and Regulations is contrary to the laws or the applicable regulations its invalidity shall not effect any other clause or section of these Bylaws.

SECTION 9. WOUND TREATMENT AND HYPERBARIC CARE CENTER

The Wound Treatment and Hyperbaric Care Center is a clinic dedicated to patients needing specialized treatment for chronic and severe wounds. The Wound Care Center consists of medical treatment rooms and hyperbaric oxygen chambers. A physician order is not required for a patient to be referred to the treatment center. The nursing staff will assess the condition of the wounds and refer the patient to the physician on the Center schedule for further treatment.

Physicians who care for patients in the Wound Treatment and Hyperbaric Care center must be:

- A. In standing with the Medical Staff of Sweeny Community Hospital and maintain their privileges according to the By-Laws of the Hospital.
- B. Trained in Hyperbaric Oxygen Therapy if seeing patients for HBOT care in the clinic. They must have completed at least 40 hours of CME in Hyperbaric Medicine at the American College of Hyperbaric Medicine and /or the Undersea and Hyperbaric Medical Society as certified by the International ATMO. Physicians may also have completed a medical residency in Hyperbaric Medicine and /or be Board Certified to supervise HBOT. Physicians who have not completed the necessary hours cannot supervise or practice Hyperbaric Oxygen Therapy.

Routine wound care may be performed by any physician or podiatrist who have completed residency and /or Board Certification in the American Board of Medical Specialties or are board certified in podiatry. General Surgeons may practice all wound care procedures according to their residency and /or Board Certification.

It is recommended that physicians who practice wound treatment or Hyperbaric Medicine gain further proficiency by devoting CME's to the practice of wound care.

All medical records in the Wound Care Center will be interfaced with the hospital EMR.

A medical director shall oversee the Wound Treatment and Hyperbaric Care center including its policies and procedures and the treatment of all patients.