

**RULES AND REGULATIONS
of
THE MEDICAL STAFF
WARM SPRINGS SPECIALTY HOSPITAL AT LULING**

All members of the Medical Staff of Warm Springs Specialty Hospital at Luling will abide by the Medical Staff Bylaws, and these Rules and Regulations which have been adopted by the Medical Staff pursuant to Article XVI of the Bylaws. Terms defined in the Bylaws which are used in these Rules and Regulations shall have the meaning given to them in the Bylaws.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a member of the Active or Courtesy Staff. All Practitioners shall be governed by the admitting policy of the Hospital. Admission criteria must be met at the time of admission.
2. A physician member of the Active or Courtesy Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for assuring transmission of reports of the condition of the patient to the referring practitioner and family. Whenever these responsibilities are transferred to another member of the Active Staff, a note covering the transfer responsibilities shall be entered on the order sheet of the medical record.
3. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been recorded.
4. Each member of the Active Staff, Courtesy Staff, and Provisional Staff who does not reside in the immediate vicinity of the Hospital shall name a member of the Active Staff who is a resident in the area who may be called to attend his patients in an emergency or until he arrives. In the case of failure to name such Active Staff member, the Administrator or the Medical Director shall have authority to call any member of the Active Staff.
5. Each Practitioner must assure timely, adequate, professional care for his patients and the Hospital by being available or having available through his office or answering service an eligible alternate Practitioner with whom prior arrangements have been made and who is on active staff. Failure of a Practitioner to meet these requirements shall result in the loss of Clinical Privileges.
6. All long term acute care patients admitted to the Hospital shall be seen within 24 hours after their admission by the admitting physician or his designated member of the Medical Staff. Thereafter, all hospitalized patients will be seen by their attending physician or his designated member of the Medical Staff at least every two days. Documentation in the medical record must be performed at least every two days. For patients receiving skilled care in the swing bed program, physician visits and documentation will occur at least once weekly.
7. 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 patients might be a source of danger from any cause whatsoever.

8. The attending physician is required to participate in the Hospital utilization management program. The attending physician shall review pre-admission information to ensure the patient meets admission criteria. The attending physician is required to document the need for continued hospitalization. This documentation shall include:
 - a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
 - b. The estimated period of time the patient will need to remain in the Hospital.
 - c. Plans for post-hospital care and current discharge planning.

The attending physician and the treatment team shall determine the need for continued stay at the time of the patient care conference, including discussion of discharge planning. The Utilization Review Committee, acting as the Medical Executive Committee, is used to resolve admission or continued stay conflicts.

9. Patients shall be discharged only on written order of the attending physician and a discharge diagnosis shall be recorded. If a patient leaves the Hospital against the advice of the attending physician or without proper discharge, a notation to that effect shall be made in the patient's medical record.
10. In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or a designee authorized by Hospital policy within a reasonable time. The Hospital's policy on organ donation shall be followed. Exceptions shall be made in those instances of incontrovertible and irreversible disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of the body shall conform to local law.
11. Autopsies shall be requested and performed in accordance with the criteria and procedures set forth in the Hospital's Autopsy Policy.

B. GENERAL CONDUCT OF CARE

1. A general consent form signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The Admissions Department should notify the attending Practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.
2. All orders for treatment, including orders for drugs and biologicals, shall be in writing, dated and signed or initialed by the Practitioner responsible for the care of the patient. An order shall be considered to be in writing when signed by the physician if dictated to a licensed nurse. In addition, the following persons are authorized to receive telephone or verbal orders directly related to the practice of their specialty:
 - a. Clinical Dietician
 - b. Occupational Therapist
 - c. Pharmacist
 - d. Physician Assistant
 - e. Physical Therapist
 - f. Respiratory Therapist

- g. Case Manager
- h. Speech Pathologist
- i. Neuropsychologist
- j. X-ray Technician

Telephone or other verbal orders are to be used infrequently and when used, must be signed or initialed by the Practitioner who gave the order on his or her next visit to the patient. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

3. The Practitioner's orders 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, continue, and change" orders are not acceptable. Original order is to be discontinued and the new order written.
4. All drugs and medications administered to the patient shall be those listed in the latest edition of the Hospital formulary approved by the Medical Staff listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations.

Drugs for bonafide clinical investigations may be exceptions. These shall be used in full accordance with the accepted principles, policies and procedures within the Hospital and all regulations of the Federal Drug Administration.

5. Controlled substances: Schedule II. All Schedule II controlled substances shall be reviewed weekly during hospital stay. Upon admission, physicians may write DHS, during hospital stay. These orders should not be discontinued without notifying the physician.
6. Controlled substances: Schedules III, IV, and V. All Schedule III, IV, and V controlled substances shall be automatically discontinued after 30 days unless reordered by physician or after a specified time ordered by the physician has elapsed. These orders should not be discontinued without notifying the physician. The physician shall be notified as in number 5 above.
7. Antibiotics and anti-infectives: All drugs of these classes shall be automatically discontinued after ten days or after a specified time ordered by the physician has elapsed. Parenteral and oral antibiotics shall have an automatic discontinue status after 10 days. The physician shall be notified as indicated in number 5 above.
8. Steroids: All drugs of this class shall be automatically discontinued after seven days for parenteral steroid preparations and 10 days for oral steroid preparations or after a specified time ordered by the physician has elapsed. Physician shall be notified as indicated in number 5 above.

9. Anticoagulants: All drugs of this class shall be automatically discontinued after seven days for intravenous anticoagulants or 30 days for oral and all other subcutaneous anticoagulants or after a specified time ordered by the physician has elapsed. The physician shall be notified as indicated in number 5 above.
10. All other drugs not mentioned above shall be automatically discontinued after 30 days. These orders should not be discontinued without notifying the physician. The physician shall be notified as in number 5 above.
11. The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rest with the Practitioner responsible for the care of the patient. It is the duty of the Active Staff to see that those with Clinical Privileges do not fail in the matter of calling consultants as needed.
12. The attending Practitioner is primarily responsible for requesting consultations when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending Practitioner to attend or examine his patient, except in emergency.
13. 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 attained, he shall call this to the attention of the supervisor who in turn may refer the matter to the Senior Nurse Executive. If warranted, the Senior Nurse Executive, through the Administrator, may bring the matter to the attention of the President of the Medical Staff or the Medical Director. Where circumstances are such as to justify such action, the President of the Medical Staff or the Medical Director may himself request consultation.
14. Heparin flush orders need state only "heparin flush". Nursing protocols will then be initiated.
15. Hyperbaric medicine - The standard of care for hyperbaric oxygen treatments requires that a physician trained in hyperbaric medicine is present during all hyperbaric patient treatments. At a minimum, the physician will be present in the Hospital and immediately available to the hyperbaric unit.

C. EMERGENCY SERVICES

A Medical Staff member stabilizes patient and notifies emergency transport services.

D. LABORATORY SERVICES

1. The Hospital provides laboratory services to perform all types of commonly requested examinations. If necessary, tests shall be referred only to Hospital-approved reference laboratories.
2. Laboratory services may be provided by a contracted service. All requests and specimens related to clinical pathology or pathologic anatomy to be processed outside of the Hospital shall be submitted to the contracted consultant pathologist and all reports shall be returned to the medical record. All anatomic and clinical pathology reports or analysis done outside of the Hospital shall be used at the discretion of the admitting physician, that is if these

reports are prepared by someone other than the contracting consultant pathologists in association with the Hospital.

E. DISASTER PLAN

1. The Active Staff will participate in the Hospital's External Disaster Plan.
2. All physicians not permanently assigned to duties during actual disasters or disaster exercises shall report to The Incident Command Center for assignment. The location of The Incident Command Center designated in the External Disaster Plan. The President of the Medical Staff and/or the Medical Director and the Administrator will work as a team to coordinate activities and directions. In case of evacuations of patients from one area of the Hospital to another, or evacuation out of the Hospital, the Medical Director will authorize the movement of patients.

F. MEDICAL RECORDS

1. A complete history and physical examination shall in all cases be written or dictated and on the record within 24 hours of the patient's admission. A history and physical examination completed within seven days before admission is acceptable if the patient's condition did not significantly change during this time. Any significant changes must be noted at the time of admission.

No patient shall be treated in the Hospital until an admission diagnosis has been recorded. An admission note must be recorded within 24 hours after admission. The admission note is a brief summary for the history of the illness which includes the duration, symptoms, pertinent physical findings and treatment prior to admission.

2. Clinical entries in the patient's medical record shall be accurately dated and authenticated. Authentication means to establish authorship by written signature or identifiable initials.
3. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. The master list is kept on file in the Health Information Management Department and a copy is available at the nursing unit for reference. The master list also specifies symbols and abbreviations deemed unacceptable, and they shall not be used.
4. The attending physician shall be responsible for the preparation of a complete medical record for each patient. This record shall include the following:
 - a. Identification Data
 - b. History - Includes relevant:
 - (1) History of present illness (reason for admission to Hospital)
 - (2) Past medical history
 - (3) Social history
 - c. Physical Examination - Includes:
 - (1) Review of body systems (related to present illness)
 - (2) General systems, including HEENT (Head, ears, eyes, nose, throat), lungs, abdomen, extremities, neurological.

- d. Impression/Diagnosis
- e. Plan of Care or Goals

The above list represents minimal components required for the history and physical examination. Physicians are expected to use their professional judgment in including additional information based on individual patient status. Templates provided by the Hospital's Health Information Management Director shall be used when applicable.

Practitioners are expected to use the entire patient record as an instrument for providing and obtaining information on the patient served. Although the physician's history and physical examination is considered a vital part of the record, the rehab team functions as a team to ensure all necessary information is provided in the record as a whole.

- f. Discharge Summary
 - (1) Hospital Course
 - (2) Discharge Condition
 - (3) Discharge Diagnosis
- g. Progress Notes
 - (1) Provisional diagnosis and admission notes
 - (2) Routine visit or procedure notes
- h. Clinical laboratory and diagnostic studies-as applicable, Consultation (s) -as applicable.
- i. Pathological Findings
- j. Diagnostic & therapeutic orders
- k. Informed consent
- l. Follow-up and Autopsy Report, if applicable

- 5. No medical record shall be filed until it is completed except on order of the Executive Committee.
- 6. If admitted for less than 48 hours, a short stay summary may be used containing, as applicable, a chief complaint, present illness, salient points of the past history, a brief physical examination of major systems, and emphasizing outstanding abnormalities, progress notes, final diagnosis, condition on discharge, medications, diet, activity limitations, follow-up and surgical procedure, if any.
- 7. All medical records will be completed within 30 days post discharge.
- 8. All Medical Staff members should edit, correct or amend and countersign at least the history, physical examination, and summary written by the authorized resident, intern, or senior medical student. In all instances, the physician should sign clinical entries made by himself. All entries made by a physician's assistant shall be countersigned by his supervising physician or the attending physician.

9. The Director of Health Information Management shall prepare a monthly statistical report of record completion compliance which shall be made available to members of the Active Staff or any member of the Medical Staff who so requests. The report is presented to the Executive Committee for review and action if necessary to address delinquent records.
10. Access to medical records of all patients shall be afforded to members of the Medical Staff in good standing for bonafide study and research at the discretion of the Administrator.
11. After the record has been completed and filed, no erasures, deletions, alterations, corrections, additions or other changes shall be made. Signed and dated addendum to the record may be appended at any time.
12. When ordering studies, such as x-rays, electrocardiograms, electroencephalograms, uroflow studies, and similar records, the physician must supply patient diagnosis and clinical indications for the study to the healthcare professional conducting the study.
13. The medical record shall not be removed from the Hospital. Hospital policy and procedures further establishes safekeeping of the medical record.

G. GENERAL

1. When ordering radiology studies, the physician or designee must supply patient's diagnosis and clinical indications for the study to the radiologist.
2. All members of the Medical Staff will cooperate with the Dietician in the use of the master diet plan.
3. Any member of the Medical Staff who shall find fault with a member of the Hospital personnel staff shall report the deficiency to the supervisor or the department head immediately. If the Medical Staff member feels that he has not gained satisfaction by such report, he should then report the deficiency directly to the Administrator, Administrative designee, the Human Resources Director or Nursing Service Director. In no case shall an individual Medical Staff member attempt to discipline an employee except in cases where the patient may be at risk.
4. All studies, patient care evaluations, or assessments of appropriateness of care/treatment, proposed by members of the Medical Staff shall receive approval from the Medical Staff or a designated committee thereof. This will be performed as a part of their medical care quality review actions. Prior to data extraction or medical record review, the following characteristics must be approved:
 - a. The title of the study, evaluation of research.
 - b. The purpose of the study, evaluation of research.
 - c. The criteria to be used for data extraction or chart review.
 - d. Only members of the Medical Staff or designated Hospital personnel will be allowed to perform medical record review or data extraction. It shall be the policy of the Hospital to provide whatever professional attention that may be necessary or required to safeguard the rights, safety, and welfare of human subjects. These studies, patient care evaluations, or assessments of appropriateness of care or treatment will be reviewed by the Active Staff at a regularly scheduled meeting and decided on in that meeting by majority vote.

- e. The provisions of the Health Care Quality Improvement Act of 1986 (HCQA) 42 U. S. C. and Department of Health and Human Services implementing instruction, 54 Federal Register 42722 (October 17, 1989) will be complied with. Reports will be submitted to the National Practitioner Data Bank as required.