MEDICAL STAFF
RULES AND REGULATIONS
OF
Scott & White Hospital – Round Rock
Round Rock, Texas

Revised the Twenty Fifth of July 2008, Round Rock, Texas
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TABLE OF CONTENTS

1. GENERAL 3
2. PATIENT RIGHTS 4
3. ADMISSION OF THE PATIENT/ MEDICAL RECORDS 6
   a. Admission 6
      1) General Consent Form At Time Of Admission 6
      2) Diagnosis at Time of Admission 6
   b. Medical Records 6
      (1) Patient's Medical Record 6
      (2) Content of the Medical Record 6
      (3) Delinquent Medical Records 7
      (4) Consultation Notes 7
      (5) Surgery 7
      (6) Discharge Summaries 8
      (7) Progress Notes 8
      (8) Diagnostic Testing 8
      (9) Autopsies 8
      (10) Conditions of Hospital Records 9
      (11) Signatures 10
4. TREATMENT OF THE PATIENT 10
   a. Informed Consent 11
   b. Patients with Communicable Diseases 11
   c. Reassessment of the Patient 11
5. POLICIES AND PROCEDURES OF THE MEDICAL STAFF OR HOSPITAL 12
6. ADOPTION AND SIGNATURES 12
Scott & White Hospital – Round Rock  
Round Rock, Texas  

Rules and Regulations of the Medical Staff

These Rules and Regulations are adopted to supplement the Bylaws of the Medical Staff of Scott & White Hospital – Round Rock (the “HOSPITAL”).

All Practitioners providing services at the HOSPITAL, upon accepting staff appointment and/or assigned clinical privileges shall abide by these Rules and Regulations. Failure to do so shall constitute a breach of the appointment and subject the offender to such disciplinary action deemed necessary, as provided in the Bylaws of the Medical Staff of the HOSPITAL.

1. GENERAL

   a. All Practitioners shall be expected to be familiar with and abide by the Bylaws and these Rules and Regulations of Scott & White Hospital – Round Rock.

   b. Only members of the Active, Courtesy and Consulting Staff may admit patients to the HOSPITAL, except as provided in the Medical Staff Bylaws. Active Medical Staff members shall be given priority for non-emergency admissions.

   c. Members of the Medical Staff are required to support the charitable, emergency care, and educational responsibilities of the institution.

   d. An appropriate physician member of the Medical Staff is responsible for the medical care of each patient. Non-physician practitioners shall be permitted to practice within the terms of their licensure, registration, certification, training, and experience.

   e. Any Practitioner assigned to on-call duty should remain sufficiently close to the HOSPITAL during his/her tour of duty to enable him/her to meet the response times specified within the HOSPITAL’s on-call coverage policies. In the event a Practitioner is unable to meet the criteria, the Practitioner who is on call is responsible to assign an alternate Practitioner, with equivalent privileges, to provide timely, adequate professional care for patients.
f. All scheduled absences that involve the duty roster schedule are to be submitted to the Chief of Staff or designee at the earliest possible date so that schedule and duty rosters may be arranged to ensure full coverage. The Chief of Staff or designee should be notified as soon as possible in the event of emergency or unexpected absences.

g. Each Section shall establish an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems. Members of the Medical Staff are required to participate in such quality improvement programs as outlined by Hospital Administration.

h. The Hospital cannot and does not practice medicine. Thus, while these Rules and Regulations should be referred to routinely by the members of the Medical Staff, they are in no way intended to prevent any Medical Staff member from exercising medical judgment within his/her area of competence.

2. PATIENT RIGHTS

The Hospital and Medical Staff have adopted the following statement of patient rights. Patient rights include, but are not limited to, the following rights:

a. To have a family member or representative of his/her choice and his/her own physician notified promptly of his/her admission to the HOSPITAL.

b. To expect personal privacy and confidentiality of medical information as required by law.

c. To formulate advance directives and to have HOSPITAL staff and Practitioners who provide care in the HOSPITAL comply with these directives.

d. To receive a copy of this summary, as well as the name and phone number of the staff member to whom questions or complaints can be directed.

e. To receive, upon request, the HOSPITAL’s written policies and procedures regarding life-saving methods and the use or withdrawal of life-support mechanisms.

f. To receive an explanation from the treating Practitioner of his/her medical condition, recommended treatment, expected results, risks involved, and reasonable medical alternatives, if applicable.

g. To participate in the development and implementation of his/her plan of care, if able.
h. To give informed, written consent (if required by applicable law) prior to the start of specified, non-emergency medical procedures or treatments.

i. To refuse medication and treatment after possible consequences of this decision have been explained clearly, unless the situation is life-threatening or the procedure is required by law.

j. To be included in experimental research only upon providing informed written consent.

k. To receive the services of a translator or interpreter, if necessary.

l. To be informed of the names and functions of all healthcare professionals providing personal care.

m. To be informed of the names and functions of any outside healthcare and educational institutions involved in providing treatment.

n. To be transferred to another facility upon request or if the HOSPITAL is unable to provide appropriate medical care.

o. To receive from a Practitioner advance explanation of the reasons for a transfer to another facility.

p. To be treated with courtesy, consideration and respect.

q. To obtain a copy of his/her medical records at a reasonable fee and within a reasonable time frame after submitting a written request to the HOSPITAL.

r. To be free from physical and mental abuse and/or harassment.

s. To be free from unlawful restraints.

t. To safe implementation of restraint or seclusion by trained staff.

u. To receive treatment and medical services without discrimination based on race, color, age, religion, national origin, sex, sexual preferences, or disability.

v. To file a grievance if he/she believes he/she has been subjected to discrimination, prematurely discharged, subjected to substandard care, or has otherwise been treated by the HOSPITAL in an unsatisfactory manner.
3. ADMISSION OF THE PATIENT/ MEDICAL RECORDS

a. Admission

(1) **General Consent Form at Time of Admission** - A general consent form, signed by or on behalf of every patient admitted to the HOSPITAL, should be obtained at the time of admission.

(2) **Diagnosis at Time of Admission.** Except in an emergency, no patient should be admitted to the HOSPITAL until a provisional diagnosis or medical reason for admission has been stated. In the case of an emergency, such statement should be recorded as soon as possible. Practitioners admitting emergency cases should be prepared to justify to the President of the Medical Staff and/or Hospital Administration that the emergency admission was medically necessary. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient’s record as soon as possible. A Practitioner from an appropriate section shall be assigned to the patient in accordance with section schedules.

b. Medical Records

(1) **Patient’s Medical Record** - A member of the Medical Staff shall assure that each patient has a complete and legible medical record.

(2) **Content of Medical Record** - The content of the medical record contains appropriate data required in the care of each patient.

Each medical record may include the following, as appropriate:

i. Patient identification data;
ii. Social/family history
iii. Reports from referral sources, if provided;
iv. A history and physical that meets the requirements set forth in Section 3(b)(4) below;
v. Admitting diagnosis;
vi. Reports of assessment;
vii. Reports from outside consultation including laboratory, radiology, etc.;
viii. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;
ix. Properly executed consent forms for procedures and treatments;
x. Evidence of known advance directives;
x. Diagnostic and therapeutic orders, if any;
xii. Treatment plans;

xiii. Daily nursing notes;

xiv. All Practitioners’ orders, reports of treatment, medication records, radiology and laboratory reports, vital signs, and other information necessary to monitor the patient’s condition;

xv. References to audio/visual records;

xvi. Service and progress reports authenticated and dated by the author of each entry;

xvii. Releases of information;

xviii. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;

xix. Follow-up reports; and

xx. Final diagnosis with completion of medical records within 30 days following discharge.

(3) Delinquent Medical Records – All Practitioners are responsible for completing their medical records within 30 days of a patient’s discharge. Any Practitioner with a delinquent medical record of 30 days (30 days post discharge) who has not made a good faith effort to resolve the delinquency will be subject to disciplinary action in accordance with the Hospital’s Medical Staff Bylaws. Section Chiefs will continue to be appraised on a monthly basis of the delinquent record status of their Practitioners and will be notified one week in advance of any Practitioner approaching the 30-day delinquency limit.

(4) Consultation Notes – Consultation notes should be clearly marked “consultation,” listing the name of the consulting service and the practitioner who performed the consultation, and be authenticated by the practitioner who performed the consultation. The note should contain the nature of the clinical problem being addressed through consultation, pertinent and physical findings, a diagnosis, if appropriate, and recommendations. There should be documentation by the appropriate Medical Staff member as to participation in the consultation. Consultation notes should 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 should 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 should, except in emergency situations so verified by the record, be recorded prior to the procedure.

(5) Surgery. A preoperative diagnosis should be recorded prior to surgery. A brief post-operative note will be recorded in the medical record immediately after surgery, containing the following elements:

- The name of the primary surgeon and assistants;
• Procedures performed and description of each procedure;
• Findings;
• Estimated blood loss;
• Specimens removed; and
• Post-operative diagnosis.

A detailed, dictated operative report containing a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the names of the responsible practitioner and assistants performing the procedure should be filed in the hospital record as soon as possible after surgery and authenticated by the surgeon. Minor surgical procedures performed outside the operating room should be clearly documented in the progress notes, by any entry, which contains the pertinent facts and is authenticated by the Medical Staff member. There should be documentation by the Medical Staff member as to participation in the procedure.

(6) Discharge Summaries - A discharge summary (clinical resume) should summarize concisely 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. All discharge summaries should be authenticated by the responsible Medical Staff member. Patients should be discharged only by a written order of a Practitioner who is a credentialed member of the Medical Staff. Should a patient leave the HOSPITAL against medical advice, or without proper discharge, a notation of the incident should be made in the patient’s medical record.

(7) Progress Notes – Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care and transferability. The timeliness of progress notes should be based on the acuity of the illness of the patient.

(8) Diagnostic Testing – 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. Reports of pathology and clinical laboratory examination, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic procedures should be completed promptly and filed in the HOSPITAL record as soon as possible after completion.

(9) Autopsies - When an autopsy has been performed, the provisional anatomical diagnosis should be recorded on the hospital record within two
(2) working days, and the complete protocol should be completed and filed in the hospital record within sixty (60) days unless a special study has been requested.

(10) Conditions of HOSPITAL Records

i. The HOSPITAL record must be completed within thirty (30) days after the patient is discharged. The Medical Staff member responsible for patient care at the time of discharge is responsible for completion of the HOSPITAL medical record.

ii. A HOSPITAL record should not be permanently filed until it has been completed by the appropriate Medical Staff member.

iii. The HOSPITAL record should contain evidence of informed consent for procedures and treatment as required by state law or standards of practice.

iv. Whenever patient care responsibilities are transferred to another Medical Staff member, the transferring Medical Staff member should immediately enter an order covering the transfer of responsibility to the other Medical Staff member.

v. All orders for treatment, including verbal orders, should be documented, dated, and authenticated by the physician/resident writing the order. Physicians familiar/involved with the care of the patient should authenticate such orders. Verbal orders should be used infrequently. HOSPITAL policy will define who is authorized to accept and transcribe verbal orders. Verbal orders should not be taken for chemotherapeutic agents. Verbal orders must be dated, signed and authenticated within 48 hours by the ordering Practitioner (or by another Practitioner who is responsible for the care of the patient and initialed by the prescribing Practitioner as soon as possible). A signed order for outpatient tests and procedures is required. The scheduling of an outpatient test or procedure is not considered an order. Orders which are illegible or improperly written will not be carried out until verified and understood by the care giver. All previous orders are cancelled when a patient enters a different level of care.

v. Contingent upon an order from an approved practitioner for an evaluation and the development of a therapeutic plan of care, licensed physical therapists and occupational therapist, and speech pathologist are authorized by the Medical Staff to write treatment orders, within their scope of practice, as necessary to implement
the patient’s plan of care for rehabilitative services. Counter signature by the practitioner associated with the patient’s care will be obtained within 48 hours of the implementation of the plan of care, if the ordering practitioner is unavailable.

vi. All medical records of patients are the property of the HOSPITAL and should not be removed from the HOSPITAL premises and facilities except by court order, subpoena, statute, or as otherwise required or permitted by applicable laws or regulations.

vii. The use of abbreviations and symbols in the medical record should be minimized by all who document in the medical record and should not include any designated “dangerous” abbreviations. Abbreviations and symbols will not be used when recording final diagnoses and procedures. The HOSPITAL maintains a list of unapproved, dangerous abbreviations, and Practitioners at the HOSPITAL should be familiar with this list.

viii. When certain portions of the medical record are so confidential that extraordinary means are considered necessary to preserve their privacy, these portions may be stored separately, provided the complete medical record is readily available when required for current medical care or follow-up, for review functions, or for use in quality improvement activities. The medical record should indicate that a portion has been filed elsewhere, in order to alert authorized reviewing personnel of its existence.

(11) Signatures – Rubber stamp signatures are not to be used. Each user of Electronic Signature Application (ESA) must sign a statement acknowledging that they are the sole user of their ESA assigned password to access, edit and authenticate transcribed reports. Original signatures are required on certain documents by regulatory agencies and are listed in the Health Information Management Committee Policy.

4. TREATMENT OF THE PATIENT

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.
a. Informed Consent

(1) Patients, if able, have the right to be involved in health care decisions, in collaboration with a physician.

(2) To the extent permitted by law, a patient has a right to accept or reject medical care.

(3) Patients (or their legally authorized representatives, when appropriate) have the right to access information necessary to make informed treatment decisions. This information should be presented in an understandable format (e.g. in their language if they do not speak English, sign language for the deaf, or other appropriate methods).

(4) The HOSPITAL record should contain evidence of informed consent for procedures and treatment as required by state law or standards of practice. A list of approved consent forms used at the HOSPITAL, in accordance with legal requirements, should be maintained. 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.

b. Patients with Communicable Diseases

Patients with communicable diseases will be isolated in accordance with the recommendations of the Center for Disease Control, as published in the current edition of the Infection Control Plan. The nurse epidemiologist should provide information regarding isolation techniques and is authorized to notify the responsible Practitioner when the possibility of dissemination of organisms exists. The responsibility for the decision concerning isolation resides with the responsible Medical Staff member.

c. Reassessment of the Patient

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 as appropriate by the attending Practitioner or his designee, or when clinically indicated.
5. POLICIES AND PROCEDURES OF THE MEDICAL STAFF OR HOSPITAL

Policies and procedures, 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.

6. ADOPTION AND SIGNATURES

These Rules and Regulations, which are a part of the Medical Staff Bylaws of the Scott & White Hospital – Round Rock, are adopted and made effective April 27, 2012, 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:


President of Medical Staff

Date

APPROVED BY THE GOVERNING BOARD:


President, Governing Board

Date