RULES AND REGULATIONS
OF
THE MEDICAL STAFF
MORRISTOWN-HAMBLEN HOSPITAL

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RULES AND REGULATIONS
OF
THE MEDICAL STAFF

MORRISTOWN-HAMBLEN HOSPITAL ASSOCIATION

ARTICLE I. ABORTION - (OB/GYN DEPARTMENT)

Section 1. Operative or Therapeutic Abortion: This procedure is considered permissible under circumstances in which there are documented lethal defects of the fetus or circumstances in which the continuance of pregnancy will constitute a threat to the life of the expectant mother.

Every patient scheduled for pregnancy termination shall have documented in their medical record, before initiation of the procedure, the menstrual history, physical findings, and sonographic confirmation. A written, documented consultation by a physician qualified and competent to render an opinion in this area shall be required and shall be a part of the medical record before the procedure is initiated.

This policy in no way compromises or relates to emergency medically indicated termination of pregnancy.

Section 2. The operative permit clearly explaining the nature of the proposed abortion, signed by the patient and properly witnessed by one or more persons, must be on the medical record of the patient prior to any operative abortion.

Section 3. All products of conception delivered spontaneously or operatively shall be sent to the pathologist**.** The pathologist's report shall be included in the patient's medical record.

Section 4. All therapeutic terminations of pregnancy shall be reported to the Tennessee Department of Health and Environment as required by the Tennessee Code Annotated 68-3-505 (a).

ARTICLE II. ADMISSION OF PATIENTS

Section 1. Admission to Morristown-Hamblen Hospital **(**MHH**)** shall be by authorization of an Active Staff or Courtesy Staff member, as prescribed by the bylaws.

Section 2. A provisional diagnosis and admission order must be on the patient's chart at the time of admission to the hospital.

Section 3. Patients will not be admitted for psychiatric services for which the hospital is not staffed or equipped, except in dire emergency and then only as a temporary expedient.

Section 4. A new admission shall be examined by the attending physician or on call physician for the attending physician within 24 hours of admission to the hospital or sooner if warranted by the clinical conditions. (Refer to Article X, Section 2--ICU Admissions). An appropriately credentialed APP may perform the initial evaluation of patients to be admitted, but this does not substitute for the evaluation by the admitting/supervising physician. The attending physician/on call physician, or other appropriately credentialed practitioner shall be responsible for the completion of the admission History and Physical within 24 hours of admission.

Section 5. Medical services for which the hospital is adequately equipped, and which are normally provided by the hospital, shall be provided on a non-discriminatory basis. This means that those services will be provided regardless of race, sex, religion, age, national origin, creed, color, or handicap.

ARTICLE III. AUTOPSY

Section 1. Any patient expiring after admission to the hospital is considered a hospital death. It is desirable at times for such patients to have autopsies whenever possible. The hospital shall make autopsy permits available for the purpose of obtaining permission for postmortem examination. The staff is encouraged to solicit permission for autopsy from the surviving next of kin when appropriate.

Section 2. No autopsy may be performed without the signed consent of the legally responsible heir, the next of kin, or through the order of authorized officers of the court having jurisdiction in the county in which the death occurred.

Section 3. The report of such an autopsy shall become a part of the permanent medical record of the patient.

Section 4. Provisional Anatomic diagnosis should be completed within 72 hours. Final Anatomic diagnosis should be completed within 60 days.

Section 5. An autopsy is indicated if one of the following criteria is met:

Unknown and/or unanticipated medical complications may have occurred

Cause of death or a major diagnosis is not known with reasonable certainty on clinical basis

Autopsy may help family and/or public understand death and provide assurance

Unexpected death or unexplained death following any dental, medical, or surgical diagnostic procedure or therapies

Obstetric death

Prenatal and Pediatric deaths

Patient participated in clinical trials approved by IRB

Natural deaths waived by ME/Coroner such as:

a) DOA
b) Deaths within 24 hours admission to hospital
c) Deaths in which the patient sustained or apparently sustained an injury while hospitalized

Death resulted from high risk infections and contagious diseases

ARTICLE IV. CONSULTATIONS

Section 1. Consultant: A consultant shall be a qualified physician or limited license professional credentialed in accordance with Medical Staff Bylaws. [eligible for medical privileges] with medical staff membership in this hospital and competent to render an opinion in the medical area in which his opinion has been solicited.

Section 2. Required Consultations: Except in cases of emergencies, consultations with qualified physicians are required in the following situations:

A. Therapeutic Abortion
B. Medically Indicated Sterilizations

Section 3. Recommended Consultations

A. High Risk Operative Patients
B. When continued hospitalization is required due to an unclear diagnosis.
C. Therapeutic Problems

In case of questions, Department Chief, Chief of Staff, or Medical Executive Committee shall have final authority to determine the advisability of such consultation.

Section 4. Consults should be labeled non-emergent, urgent, or emergent.

A. If a consult is non-emergent, the consultant should see the patient within 24 hours of notification.

B. If the consult is urgent, the consultant should see the patient within eight (8) hours of notification.

C. If the consult is emergent, the consultant should see the patient within 30 minutes of notification.

The consultant's written report should be on the chart within 24 hours and should reflect adequate examination of the patient and recommendations for care or management of the patient's problem for which consultation is requested.

Section 5. Consultation notes required for surgery shall be recorded in the medical record prior to the operation unless immediate surgery is required to prevent loss of life or limb.

Section 6. The attending physician/on call physician should assess the patient before consultation is requested. When consultation is desired or required, it is the responsibility of the attending physician to provide the consulting doctor beforehand with specific information regarding the reason for consultation (i.e. specify points of examination, suspected diagnosis or problem, and desired level of participation of consultant in directing care of the patient). In an emergency situation, the attending physician/on call physician shall speak with the consultant directly.

Section 7. Psychiatric consultation is recommended for the patient who has attempted suicide or has taken a chemical overdose. Notes must be entered in the chart documenting that this recommendation has been made to the patient or responsible family member.

ARTICLE V. DEATH

Section 1. The County Medical Examiner and the County Coroner are to be notified by the physician of any death in which: The cause of death is uncertain; the death is sudden or unexpected; and/or the death is the result of an accident, regardless of when such accident occurred; or, in which the cause of death appears to be violent or otherwise associated with circumstances of a suspicious nature.

A. Any death occurring within 24 hours of admission to the hospital is also notifiable with regard to the Medical Examiner and the Coroner, when the patient has not been under the care of the physician certifying death for the condition causing the death.

B. In any case involving the County Medical Examiner and the County Coroner, the patient's remains, i.e. his corpse and personal property, are to be kept in the hospital until released by written or verbal order of the above mentioned authorities.

Tennessee Code Annotated Number 38-7-108 (1983) reads as follows:

Any physician, undertaker, law enforcement officer, or other person having knowledge of the death of any person from sudden violence, or by casualty, or by suicide, or suddenly when in apparent good health, or when found dead, or in prison, or in any suspicious unusual or unnatural manner, or where the body is to be cremated, shall immediately notify the County Medical Examiner or the District Attorney General, the local police, or the County Sheriff, who in turn shall notify the County Medical Examiner.

ARTICLE VI. DISASTER

Section 1. The hospital shall have and maintain an emergency preparedness plan or disaster plan. This plan may be implemented by any emergency room physician or the hospital administrator or their designee. This plan shall be reviewed and revised as necessary and made available to Medical and hospital staff.

ARTICLE VII. DISCHARGE OF PATIENTS

Section 1. Patients shall be discharged only on the order of the attending physician or designee, except in cases when the hospital is operating under the authority of the Emergency Preparedness Plan.

ARTICLE VIII. EMERGENCY ROOM

Section 1. The hospital shall maintain a center for the care and treatment of medical emergencies. The operation of the Emergency Room shall be under the supervision of the Emergency Room Committee which will develop policies and procedures for the operation of the Emergency Room.

Section 2. The Emergency Room shall offer services on a 24-hour basis.

Section 3. The screening of individuals seeking emergency medical care in the Emergency Department, for the purpose of determining whether the individual has an emergency medical condition that requires stabilizing treatment, shall be done by the Emergency Department physician, or by an appropriately credentialed Physician Assistant and/or Nurse Practitioner, privileged to perform medical screening examinations, working within the practitioner's approved scope of practice under the supervision of the Emergency Department physician. In the cases of pregnant patients in possible labor, the medical screening examination shall be done by an Emergency Department physician, OB physician, or registered nurses with special competence in obstetrics, in consultation with an obstetrician.

ARTICLE IX. EMERGENCY ROOM BACK-UP

Section 1. Each active staff physician will serve on a schedule as a back-up consultant to the Emergency Room physician according to department assignment or specialty as approved by the medical Staff. This schedule shall be posted at the hospital switchboard, in the hospital Emergency Room, Medical Staff Office, and a copy shall be provided to each participating physician.

Section 2. Any physician acting as a substitute for the assigned back-up consultant has the same responsibility as the assigned physician and is required to provide advance notice to the switchboard, house supervisor, and Emergency Room.

Section 3. When the Emergency Room back-up consulting physician signs out to another member of the Medical Staff, the physician accepting ER backup cannot sign out to another Medical Staff member during this assignment. The person accepting ER backup must accept responsibility and/or Patient Care Management for any type of problem within that specialty.

Section 4. A consulting physician on the back-up schedule is to be available for consultation to the emergency room physician within a reasonable amount of time after notification.

Section 5. An active staff physician serving on the schedule as a back-up consultant to the Emergency Room will respond within a reasonable amount of time after notification. After contact is made, the back up consulting physician must present to the Emergency Room in an appropriate amount of time upon request by the Emergency Room physician.

Section 6. Any medical staff member having obtained the age of sixty (60) or with 25 years on the medical staff at this Hospital may be, upon written request, relieved of Emergency Room back-up call without affecting attending staff privileges.

ARTICLE X. INTENSIVE CARE UNIT

Section 1. The operation of the Intensive Care Units will be under the supervision of the Special Care Committee. The chairman of the Special Care Committee shall provide medical direction to the Intensive Care Units.

Section 2. For all Intensive Care Unit admissions, the attending physician/on call for the attending physician shall see and assess the patient within 8 hours of admission. All Admissions to the Intensive Care Unit shall be subject to review by the Special Care Committee and/or Chairman.

Section 3. The attending physician shall revise and review orders on all patients transferred from other care areas into the Intensive Care Unit. All prior orders shall be automatically discontinued upon admission to or discharge from the Intensive Care Unit.

Section 4. A patient will be admitted to the Intensive Care Unit in accordance with the severity of illness and the need for admission to The Intensive Care Unit. If a conflict arises concerning admission and discharge, the Special Care Committee Chairman will serve as the final authority.

ARTICLE XI. MEETINGS

Section 1. Regular meetings of the General Medical Staff will be held on the third Tuesday of every other month at 7:00 P.M. in the Morristown-Hamblen Hospital cafeteria or designated location**.**

Section 2. Medical Staff Departments and Committees of the Medical staff shall meet as directed by the bylaws of the Medical Staff. Each Department and committee shall designate a time and place for their meeting.

ARTICLE XII. OB/GYN DEPARTMENT

Section 1. A standard hospital consent form for labor and delivery shall be obtained and maintained on all obstetrical patients. The standard hospital form for the conduct of labor and delivery shall be maintained on labor patients. A prenatal record, when available**,** with a completed history and physical is required as part of an obstetrical admission**.**

Section 2. Physicians engaged in obstetrical practice must keep the labor and delivery room and obstetrical floor apprised of their whereabouts and be reasonably accessible. When the physician is not available, they must designate a qualified staff member to be responsible for their obstetrical practice and notify the Labor and Delivery Room and obstetrical floor as to their substitute.

Section 3. The induction and stimulation of labor shall be initiated only on the direct order of the attending physician after the patient has been properly assessed.

Section 4. Oxytocic drugs shall be used with caution on the pregnant patient. When such drugs are used, a qualified observer shall monitor the patients' progress. Ergot derivatives shall not be administered to undelivered obstetrical patients.

Section 5. No patient shall be left unattended while in delivery position in the birthing bed.

Section 6. Once the patient is admitted to Labor and Delivery, the attending physician or his qualified designee must see and assess the patient within two (2) hours.

ARTICLE XIII. ORDERS

Section 1. No treatment or medication or diagnostic procedure may be ordered on any patient in this hospital without the expressed order of a physician, or limited licensed professional acting within scope of their clinical function either written or verbal, except in cases where immediate action is required for preservation of life or limb of a patient.

Section 2. Verbal orders may be written on the chart of the patient by a Registered Nurse, L.P.N., and countersigned by the attending physician.

The following may write department specific orders in the Medical Record after discussion with the physician:

A. Registered Dietitians (Diet Orders)
B. Pharmacist (Medication/TPN Orders)
C. RRT or CRRT (Ventilator, Bronchial hygiene, O_2 Therapy)
D. Physical Therapist (Orders related to functional ability)
E. Radiologic Technologists
F. Medical/Laboratory Personnel
G. Admissions Personnel for Outpatient Lab and X-Ray

Section 3. Except when the duration of dosage has been specified, all injectable narcotics shall be automatically discontinued after three (3) days. Drug usage, dosage, and duration shall be in conformity with the United States Pharmacopeia and National Formulary, except as indicated by previously approved protocol.

Section 4. Standing orders may be formulated by the attending physician. These shall be submitted to the Pharmacy and Therapeutics Committee for approval, but a request may be made by the attending physician for the immediate institution of the orders. In this event, the orders will be considered valid pending a review and approval of Pharmacy and Therapeutics Committee. Standing orders, whether approved immediately or by the committee, shall be maintained in the Medical Staff office and that office shall notify all personnel involved. Standing orders shall remain in force until changed by the attending physician and should be reviewed periodically by the attending physician.

ARTICLE XIV. PATIENT RECORDS

Section 1. The attending physician is responsible for the preparation of a complete medical record for each of their patients in this hospital including observation and day surgery patients.

Section 2. The medical record shall include data to identify the patient, appropriate informed consent, including risks, benefits, and alternatives, patient's complaint, history of present illness, past history, family history, social

history, review of symptoms (to include pertinent negative and positive symptoms referable to the major body systems), physical examination including plan of care, consultations, clinical laboratory reports, x-ray reports, operative reports/procedure reports invasive and non-invasive, special reports, pathological findings, and pertinent progress notes.

A developmental history shall be included for pediatric patients which shall include the developmental appropriateness of the child. A developmental history may be substituted for the review of systems for patients five (5) years of age and younger.

Section 3. Content of a History and Physical

- Chief Complaint
- History of Present Illness/Review of Systems
- Past History
- Family History
- Social History
- Allergies
- Current Medications
- General Physical Exam
- Impression
- Plan
- Attending physician signature, date and time

Section 4. A discharge summary shall be completed on all patients---except short stays (48 hours)---following discharge within 15 days and within 24 hours of patient's transfer to another facility.

Section 5. No medical record is to be filed by the Director of Medical Records until it is completed by the physician, except on order of the committee responsible for medical records.

Section 6. All medical records are to be completed and signed within fifteen (15) days following the patient's discharge when data permits. The loss of the physician's admission privileges will be automatic until the delinquency is cleared unless extenuating circumstances are presented to the Executive Committee.

Remaining on no bed status in excess of thirty (30) days consecutively, or forty-five (45) days total in any medical staff year shall be grounds for immediate corrective action pursuant to Article XI, Section D, 4C of Medical Staff Bylaws.

Medical record entries that must be dated and authenticated by the responsible practitioner are: Discharge Summary, History and Physical Examination, Consultation Report, Physicians Orders and Progress Notes, Emergency Room Records, Operative Records, Anesthesia Records, and Diagnostic and Procedural Reports. (Includes i.e.- x-ray- pathology, etc.)

Section 7. Any physician restricted from admitting patients due to chart delinquency may not admit patients in the name of another staff member.

Section 8. A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission for each patient by an appropriately credentialed provider. The medical history and physical examination must be present in the patient's medical record within 24 hours of admission.

When the medical history and physical examination are completed within 30 days before admission an updated medical record entry documenting an examination for any changes in the patient's condition is completed. The updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

A history and physical must be completed prior to the performance of a Medical or surgical procedure with the exception of an emergency. The appropriately credentialed provider qualified to perform the history and physical writes an update note addressing the patient's current status and/or any changes in the patient's status.

Completion of history and physical within 24 hours is monitored. Physicians who (consistently) do not complete history and physical within 24 hours are subject to applicable rules under Article XIV, section 5 of Rules and Regulations.

Operative procedure reports are dictated or written immediately after the procedure. An operative progress note (postop note) is entered in the medical record immediately after the procedure.

Interpretation turn-around times for the following diagnostic studies must be completed in time frames listed:

Arterial Doppler	36 hours
Carotid Doppler	36 hours
EEG	36 hours
EKG	24 hours
Holter Monitor	36 hours
Pulmonary Function	36 hours
Segmental Pressure	36 hours
Stress Testing	36 hours
2D Echocardiogram	36 hours
Sleep Studies	15 days
Venous Doppler	36 hours

Section 9. The patient's original medical record is the property of the hospital and is not to be removed from this hospital without proper subpoena or as required by statute, except for x-ray films.

Section 10. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bonafide studies and research, consistent with preserving the confidential nature of such personal information concerning the individual patients. Subject to the discretion of the Administrator, former members of the medical staff shall be permitted free access to information from medical records of their patients during any periods when they attended such patients in this hospital.

Section 11. All final diagnoses and any complications shall be recorded in full without the use of symbols or abbreviations. Only those symbols and abbreviations approved by the medical staff shall be used in other portions of the medical record.

Section 12. Patients admitted to the hospital for dental and podiatry care shall receive the same basic medical appraisal as patients admitted for other services. This includes the performance and recording of findings in the medical record by a physician member of the medical staff of an admission history and physical examination and an evaluation of overall medical risk. The dentist is responsible for that part of the history and physical examination related to dentistry.

Section 13. The minimum frequency of visitation to a hospitalized patient (excluding Geropsych services*)* by the attending physician or his/her designated physician should be every day and that visit shall be documented in the medical record.

The minimum frequency of visitation of a pediatric patient by a physician shall be every day and each visit shall be documented in the record.

Section 14. Clinical Documentation by Qualified Participants in Professional Education Programs:

It is the policy of Morristown-Hamblen Healthcare System to permit qualified participants in professional education programs, such as medical students, interns and residents, to participate in training, education and practice opportunities at this facility.

Charting guidelines for these participants are as follows:

	History & Physical Examinations	Progress Notes	Orders	Discharge Summary
Medical Students	Documentation only on student documentation form. Student documentation form is not part of the permanent record.	Documentation only on student documentation form. Student documentation form is not part of the permanent record.	Medical students may not write orders.	Documentation only on student documentation form. Student documentation form is not part of the permanent record.

Interns	May perform with follow-up note from attending physician written within the next 24-hours	May write with the attending to co-sign on the next visit.	May write orders.	May write or dictate with co-signature required.
Residents	May perform with follow-up note from attending physician written within the next 24-hours	May write with the attending to co-sign on the next visit.	May write orders.	May write or dictate with co-signature required.

ARTICLE XV. PEDIATRIC (NURSERY)

Section 1. Standard infant formula will be used routinely.

Section 2. Nursery tests will be performed on all newborns as required by Tennessee State Law. Standard neonatal screening as determined by the Department of Pediatrics will be performed.

Section 3. Hospital protocol will be available for nurses for use on infants and will be reviewed by the physician in a timely manner.

Section 4. Physicians with newborn nursery privileges will be assigned to the on call rotation.

ARTICLE XVI. PHARMACY

Section 1. Drugs used shall meet the standards of the United States Pharmacopeia and National Formulary. Drugs for bonafide clinical investigation shall be used only upon approval of the Pharmacy and Therapeutics Committee.

Section 2. Substitution of drugs is administered in accordance with the approved Hospital Formulary.

ARTICLE XVII. REHABILITATION SERVICES

Section 1. The Medical Staff will provide clinical guidelines to the Department of Rehabilitation Therapy, through an annually appointed representative chosen from its membership. This Medical Director will act as a consultant to the staff and the Rehabilitation Therapy Department.

ARTICLE XVIII. RESPIRATORY THERAPY

Section 1. The Medical Staff will provide clinical guidance to the Department of Respiratory Therapy through an annually appointed Special Care Committee chosen from its membership. The Special Care Committee will act as a consultant to the staff and the Respiratory Therapy Department.

Section 2. Physician orders for inhalation treatment shall specify the type, frequency, and dose of medication, and, as appropriate, the type of diluent, and the oxygen concentration.

Section 3. The physician should document in the patient record a timely, pertinent clinical evaluation of the overall results of respiratory therapy. The need for long-term oxygen therapy should be documented for patients discharged on such therapy as well as pertinent discharge instructions.

ARTICLE XIV. RESTRAINTS

The intent of these Rules and Regulations is to be interpreted in accordance with Morristown-Hamblen Hospital Policy regarding restraints. These Rules and Regulations shall be understood as consistent with this Restraint Policy.

Section 1. Restraint use shall be in accordance with Hospital and Medical Staff policy. A physician order is obtained as soon as possible following initiation of restraint or seclusion for emergency situation.

Section 2. Restraint or seclusion implementation for behavior management requires face to face evaluation by the physician within one hour. Continuation of restraints requires face to face evaluation every 24 hours.

ARTICLE XX. SURGERY

Section 1. No surgical operation shall be performed without the written consent of the patient or their legal representative, except in case of extreme emergency. In such case, consent shall be obtained as soon after the operation as is possible for inclusion in the chart.

Section 2. Each operative report must include a description of the findings, the technical procedures used, the specimens removed, the pre-and postoperative diagnoses, the name of the primary surgeon, and the names of any assistants. All surgery procedures must be dictated immediately after surgery, and the typed report shall become a part of the patient's medical record.

Section 3. Any and all tissue, except specimens that do not permit productive examination as delineated by the Surgery Department Rules and

Regulations, removed from a patient at operation must be sent to the hospital pathologist who will make such examinations as they deem necessary to arrive at a pathological diagnosis. The report of the hospital's pathologist regarding these tissues shall become a permanent part of the patient's medical record.

Section 4. The operating surgeon must be in the operating room and ready to commence the operation procedure at the scheduled time, when at all possible; in no case shall the operating room be held longer than fifteen (15) minutes after the time a case is scheduled to begin. When a fifteen (15) minute wait has passed without the surgeon appearing, the following case will be moved up and may begin as soon as possible. The scheduled case which has been delayed may be rescheduled to follow at the end of the regular operating day, or with the permission of all parties concerned, may be inserted into the operative schedule for that day whenever possible.

Section 5. No patient shall undergo operative procedure without the following items being included in the permanent hospital records:

A. Pre-operative diagnosis and a statement of any factor which might complicate anesthesia.
B. A history and physical examination has been completely done with risks, benefits, potential complications, and alternative methods explained and patient is cleared for surgery. If the patient is having a procedure and the History and Physical is completed over 30 days prior to the procedure, there must be a new History and Physical examination completed.

When these requirements are not recorded before the time stated for operation, the operation shall be cancelled unless the attending physician states in writing that such delay would constitute a hazard to the patient. The Chairman of the Surgery Department or the Director of the Surgery Department shall be empowered to ensure the staff compliance with these requirements.

Section 6. Policies and procedures for day surgery shall be consistent with those applicable to inpatient surgery, anesthesia, and post-operative recovery.

Section 7. In the event that a patient is undergoing a surgical procedure within the operating room by a non-physician (i.e. podiatrist or dentist), a physician must be present within the facility and available to the operating room.

ARTICLE XXI: Professional Practice Evaluation Committee (PPEC)

Section 1. The Vice Chairs for each department will serve on this committee in addition to a member at large. The committee with also be able to request assistance from other members of the medical staff on an as needed basis. Members of the MEC will not be eligible to serve on this committee. The

PPEC will review cases forwarded from the clinical specialty reviewers and Leadership Council. The PPEC will also review the determinations from prior levels of review to ensure consistency, support interventions and support Clinical Specialty Reviewers. Behavior reports will be reviewed with the PPEC committee for intervention or advancement of report to the MEC.

In addition, the PPEC will consist of the following support staff:

Section 2. Professional Practice Evaluation (PPE) Support Staff: Currently the Quality office serves as peer support staff. This will remain the same with the creation of the Professional Practice Evaluation Committee (PPEC). Charts for peer review will continue to be identified through department triggers, reported concerns, sentinel events, litigation risks and patient complaints. Staff will prepare charts for the clinical specialty reviewer. PPE Support Staff will log each case into a central spreadsheet to track cases sent for review. Quality care manager will prepare any behavior reports for review.

Section 3. Leadership Council: Plan will be initiated to formalize the Leadership Council which will include CAO, CNO, Chief of Staff, Vice-Chief of Staff, Quality Care Manager, and Immediate Past Chief of Staff. Optional member: PPEC Chair. Peer review may be discussed with the Leadership Council for direction. Leadership Council may refer a case to the PPEC. This council will also review behavioral reports and forward to the PPEC as needed.

Section 4. Clinical Specialty Reviewer: Currently the department chairmen serve as our Clinical Specialty Reviewers. We will observe the current policy in respect to sending peer reviews to reviews outside the facility for cases of competitors and partners, or at the direction of the Leadership Council. This will remain the first step of review in the new process with the creation of the PPEC. Rather than using the current categories for peer review 1-4, classification of “No Concern” or “Some Concern” will be implemented in the future. If the case has been determined to have “Some Concern” regarding practice, it will be forwarded to the PPEC committee for further review.

Adopted by the Medical Staff: May 17, 2016

Approved by Covenant Board and effective: May 26, 2016