

METHODIST MEDICAL CENTER OF OAK RIDGE

MEDICAL STAFF RULES AND REGULATIONS

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General Medical Policies

I. Inpatient Care

- A. All inpatients shall be seen at least daily by a physician or an appropriately credentialed advanced practice professional. If the supervising physician chooses for the APP to perform daily rounds, the APP will function under the direct supervision of the collaborating physician/group. Evidence of communication between the supervising physician and APP is required in the medical record daily.
- B. A proper history and physical examination shall be performed and dictated or written for all patients within 24 hours of admission by an appropriately credentialed individual. The attending physician will sign or co-sign all history and physicals.
- C. A proper discharge summary shall be dictated or written on all hospital stays longer than 48 hours and should briefly cover all pertinent aspects of the hospitalization. This summary should include the following: All pertinent laboratory and x-ray findings, operations, consultations, admitting and final diagnoses, discharge instructions to the patient, and the patient's condition at discharge.

II. Physicians Orders, Receiving and Implementing

STATEMENT OF STANDARD OF CARE: Patients can expect licensed/certified professionals to give, receive and implement orders for care. Patients can expect accurate transcription and documentation of implementation of such orders.

POLICY:

- A. Only licensed nurses may accept verbal or telephone orders from the physician. Other persons who are credentialed in their field of service may accept and document orders which they will implement.
For example: Registered and certified respiratory therapist may take telephone or verbal orders concerning respiratory treatment that they will administer.
- B. Verbal communication of prescription medications should be limited to urgent situations where immediate or electronic communication is not feasible.
- C. All orders on the Doctor's Order Sheet, whether written, verbal or telephone, must be signed by the attending physician within 48 hours. However, if the hospital's read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, no later than fourteen (14) days after the date of the verbal order.
- D. All signatures must be legible and contain at least the first initial, last name and title (M.D., R.N., L.P.N.)
- E. Standing orders must contain sufficient and exacting information to facilitate their being used repetitiously. They must be dated and signed by the physician or covering physician.
- F. Verbal or telephone orders must be given directly to appropriate hospital staff by one of the patient's physicians. This policy applies, also, in the event that the patient or patient's family member is a physician.
- G. In certain circumstances, orders from a party other than the physician may be accepted and implemented. For example, approved physician agents (NP's or physician assistants) may write or give orders according to their respective protocols. RNs or LPNs in a physician office or in surgery may transmit verbal orders when the physician is unavailable to speak directly with hospital staff. The person receiving the order will document it on the order sheet, indicating the nurse from whom the order was relayed.

For example: V. O. or T.O. Dr. Jones/M. Smith, R.N., Office Nurse/M. Day, R.N.

- H. Verbal or telephone orders must be entered on the physician's order sheet by the person receiving the order indicating:
- Date and time
 - Physician's name
 - Name and title of person receiving order
 - Patient name
 - Drug name
 - Dosage form
 - Exact strength or concentration
 - Dose frequency and route
 - Specific instructions
 - Indication of either telephone order (T.O.) or verbal order (V.O.)
- I. A radiologist's order for X-ray prep or repeat of a procedure may be accepted by a nurse via the X-ray technician.

ESSENTIAL STEPS IN PROCEDURE:

KEY POINTS

A. Transcription

- After writing orders, the physician will pull out red or green flag on chart divider.
Orders are to be taken to unit secretary's desk.
- When unit secretary receives orders, she/he processes them using medication administration records. All ancillary department orders are entered through the computer. When all orders have been transcribed completely, the unit secretary signs her name and title, date, and time, and returns orders to team center desk.
The computer order number is written next to each order on the physician's order sheet.
- The Medication Administration Record /IV Administration Record are checked and co-signed on the Physician Order Sheet by the RN or LPN to ensure accuracy of transcription.
- When an order is unclear, or the nurse is unsure of the safety or clarity, she consults with the prescribing physician.
- Upon completion of checking orders for completeness and accuracy, the nurse will sign his/her name and title, date, time.

Red Flag - Stat Orders

Green Flag - Non-stat Orders

Unit secretary uses black ink to sign completed orders.

This is to be written in "RED."

B. Verbal Order

- The entire verbal order should be reported or "read back" to the prescriber or the individual transmitting the order and receive confirmation from the practitioner who gave the order that it is correct.

2. The content of the orders should be clearly communicated, i.e., the spelling, providing both brand and generic names of the medication, providing the indication for use, and in order to avoid confusion with spoken numbers, such as 50 mg should be repeated back as fifty milligrams – “five zero milligrams” to distinguish from 15 mg – “one five milligrams”.
3. Only approved abbreviations should be used.

III. Transfer of Patient Care

In general, an admitting physician is responsible for coordinating the care of the patient until the care of that patient has been transferred to another service or another physician. At a minimum, this transfer should be done with phone call communication. When transferring care of a patient from one service to another, the transferring physician must have a verbal agreement with the accepting physician or service.

IV. Attending Physician’s Responsibility for Signing Death Certificate

For patients including those with DNR code status who subsequently expire while hospitalized, the attending physician will be responsible for signing the death certificate.

V. Multidisciplinary Progress Notes

Multidisciplinary progress notes may include documentation by physicians, PAs, NPs, and other disciplines (e.g., RT, PT, Case Management, Social Workers, Nutritional Services, Pharmacy) to enhance and communicate between health care providers the care, treatment, and services provided to the patient.

VI. Emergency Services

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 registered nurses with special competence in obstetrics, in consultation with an obstetrician.

VII. Self-Prescribing and Treatment of Immediate Family Members

- A. Self-prescribing:
 1. A physician cannot have a bona fide doctor/patient relationship with himself or herself.
 2. Only in an emergency should a physician prescribe for himself or herself schedule IV drugs.
 3. Prescribing, providing, or administering of schedule II and III drugs to himself or herself is prohibited.
- B. Immediate Family Members:
 1. Surgical or non-surgical treatment of immediate family members should be reserved only for minor illnesses or emergencies.
 2. Appropriate consultation should be obtained for the management of major or extended periods of illness.
 3. No schedule II, III, or IV controlled substances should be dispensed or prescribed except in emergency situations.
 4. Records should be maintained of all written prescriptions or administration of any drug.

PHYSICIAN'S HEALTH

This is a complex problem. Because of the nature of the practice of medicine and the serious implications of any disability, problems involving physicians' health are often difficult to identify. They are even harder to acknowledge by the physician and his/her colleagues. This policy is an attempt to prevent such issues from being unaddressed for too long. It is also an opportunity for the members of this medical staff to encourage one another to live a healthy, happy lifestyle for the sake of our own health and that of our patients.

We recognize that a physician may not be healthy and still practice his/her specialty with competence. We realize that the path of least resistance is to work harder, longer and in spite of the physical and mental challenges inherent to the practice of medicine. But a physician's health is important to the hospital and the medical staff to the extent that it hampers or prevents the delivery of competent patient care. A physician may demonstrate poor health as a result of a variety of physical or mental disorders. Some examples include but are not limited to age, substance abuse, depression, anger, stress, and medical problems in which the disease or treatment causes a physician to function at a level that is less than adequate.

A Physician Health Subcommittee of the Medical Executive Committee (Chief of Staff, Vice Chief of Staff, chairperson of department involved, and one other member of the Medical Executive Committee to be selected by the Chief of Staff.) has been formed to facilitate the expeditious management of these issues when they arise and to develop a process that will be proactive in preventing clinical situations resulting in poor treatment due to poor physician's health by encouraging physician's attention to their physical and mental health. They will provide for the education of the medical staff about illness and impairment recognition issues specific to physicians.

This committee will further ensure that the process allows self-referral by a physician or referral by another physician or non-physician members of Methodist Medical Center organization. They will maintain confidentiality of the physician except when limited by law or the safety of a patient is threatened.

This committee will also ensure that a process exists to document the credibility of the complaint, allegation or concern.

This committee along with the Credentials Committee and the Chief Administrative Officer will ensure that the process of rehabilitation and follow-up is thorough, complete and provides for the safety of patients.

This committee will also ensure that the reporting mechanism by which medical staff leadership learns of instances of poor physician practice because of physical or mental illness is intact and functions.

To the extent possible, issues of physician health will be identified and managed separately from the medical staff disciplinary rules and regulations. This will be accomplished through a stepwise process. The initial complaint will be handled collegially between the physician and his/her department chair and/or Chief Of Staff. If there is another occurrence or the physician chooses to ignore the collegial advice of his department chair or Chief of Staff, the department chair and the Chief of Staff will meet collegially with the physician in question. If these friendly interventions do not suffice or the nature of the problem is of such gravity that it precludes non-disciplinary interventions, the Physicians Health Subcommittee will proceed in accordance with the bylaws regarding the specific incident.

IMPAIRED PHYSICIAN POLICY/INAPPROPRIATE BEHAVIOR POLICY GENERAL POLICY OBJECTIVE

It is the objective of this hospital to provide optimum care for hospital patients and to prevent and eliminate situations that may disrupt hospital operations and interfere with optimal patient care. It is also the policy of MMC and its governing board that all individuals within its facilities, and all individuals engaged in activities on behalf of the hospital or hospital patients should be treated courteously, respectfully, and with dignity. The delivery of quality care may be compromised if a member of the medical staff is suffering from an impairment. We recognize that impairment may result from a physical or mental condition.

POLICY REQUIREMENTS

All health care practitioners and employees of health care practitioners exercising clinical privileges in this hospital shall refrain from engaging in activities that may identify them as one who is impaired as defined by this policy. They shall refrain from engaging in "inappropriate behavior" as defined by this policy. Individuals who are employed by the hospital shall be governed by comparable personnel policies applicable to employees and not by this policy. No employee of the hospital, no medical staff appointee or employee of a medical staff appointee shall be subject to sanction or discipline for reporting instances raising questions concerning impairment to any member of hospital management, Medical Staff Department Chairman, or Chief of Staff as long as such reporting is done confidentially and without further publication or discussion of the report to others, except to the extent necessary to prevent recurrences or to protect the safety of any individual on hospital premises. Instances of violence, threats of violence, carrying weapons and/or intoxication shall be reported immediately to hospital security.

DEFINITION OF "IMPAIRED PHYSICIAN"

The American Medical Association defines the impaired physician as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol." Inappropriate behavior may be a symptom demonstrated by the impaired physician.

Sexual or other harassment of an individual or individuals is inappropriate behavior and may be a symptom of any impaired physician. However, this behavior is handled as a separate issue. Refer to page 9.

DEFINITION OF "INAPPROPRIATE BEHAVIOR"

"Inappropriate behavior" subject to this policy shall mean any one or more of the following:

1. Violence, meaning behavior intended to cause harm to either person or property or behavior bearing a substantial possibility of causing such harm, whether intended or not.
2. Threats of violence.
3. Carrying weapons.
4. Alcohol intoxication or use of any illegal drug or inappropriate use of controlled substances while on hospital property.
5. Inappropriate and disrespectful verbalization with respect to an individual or individuals.
6. Sexual or other harassment of an individual or individuals is inappropriate behavior. However, this behavior is handled as a separate issue. Refer to page 11.

PROCEDURE

The procedure herein described envisions a three-tiered approach as follows:

(1) The first grievance is dealt with in a collegial manner BUT the Physician Health Reporting Form (the report of the meeting between the physician and his/her department chairman/Chief of Staff) is maintained in the Medical Staff Office in the physician's quality file noting the subject discussed and the date/time of the meeting. The physician has the right to file a written rebuttal.

(2) The second tier is used for a repeated grievance (same or different category). In this instance both the chairman of the department and the Chief of Staff meet with the physician and a report is generated and is placed in the physician's quality file. The physician has the right to file a written rebuttal.

(3) The third tier is used for either the third grievance or an episode felt to warrant bypassing of either the first two tiers, and involves the Physician Health Subcommittee of the Medical Executive Committee. A report will be placed in the physician's quality file, and the physician has the right to file a written rebuttal. Any decision

to remove information placed in a physician's quality file must be approved by a simple majority of the Physician Health Subcommittee of the Medical Executive Committee. All such files are protected under the provisions of peer review and are regarded as confidential.

Any physician or employee may report concerns regarding impaired physicians. Employees should direct such concerns to their manager, or house supervisor, if the manager is not available. Physicians should submit the report form directly to the Medical Staff Office. Concerns expressed by a patient or visitor should be directed to the manager where the patient is receiving care, or the hospital patient/customer service representative, who should in turn contact the manager. The response process to activity of a physician perceived to be impaired should be promptly initiated by the individuals designated above (manager, house supervisor, physician or medical staff department chairman), and the Physician Health Report Form should be submitted directly to the Medical Staff Office. The chief of service and/or Chief of Staff will review the report. If the grievance is found to be credible, the chief of service should facilitate discussion with the physician involved. Reviews will be conducted as expeditiously as possible.

Confirmed reports of such grievances should be addressed as presented above. Some situations may be serious enough to warrant bypassing steps. Violations of this policy shall be dealt with in accordance with the Medical Staff Bylaws. Repeated instances or instances of such serious nature that steps I and II are omitted may be deemed grounds for summary or precautionary suspension, and removal from the premises under the authority of the Bylaws. Nothing herein shall prohibit collegial or informal attempts to address the "impaired physician".

The "Physician Health Report Form" is to be used in all instances where inappropriate or dysfunctional activity is reported, whether of or by members of the hospital or medical staff. Incident reports (System Improvement Reports) are not to be used to report behavioral issues.

1. Tier One

If a grievance is submitted by hospital staff, investigated and found to have merit, the manager forwards the Physician Health Report Form to the Medical Staff Office. If a grievance is submitted by another physician, the Medical Staff Office notifies the appropriate chief of service and Chief of Staff. After receiving a grievance found to be credible, the chairman of the appropriate department should facilitate discussion with the physician involved to resolve the issue. The Chief of Staff is to be informed before the physician is approached by his/her department chief. In this step, and all subsequent steps, the individual who reported the grievance should be informed that his/her concern has been addressed and encouraged to inform the individual handling the grievance of any future concerns. The discussion between the department chief and the physician is to be collegial and limited to the facts as reported. The chairman shall initiate such discussion and emphasize that any inappropriate conduct must cease. A report is maintained in the Medical Staff Office. In most instances, this initial approach should be collegial and is designed to be helpful to the physician and the Hospital; however, depending on the severity of the behavior, a more serious and formal approach may be needed. After this discussion, the matter is closed unless further written reports are received.

2. Tier Two

If another grievance is reported and found to be credible either through the hospital or medical staff, the Chief of Staff is then notified. The Chief of Staff and the chairman of the appropriate department then meet with the physician. This meeting constitutes a more serious step than Tier One. During a Tier Two meeting the physician is reminded again of his/her responsibilities and the specific behavior(s); event(s) are discussed; firm understanding must be assured by the physician regarding his obligations to his/her patients. This understanding is documented by letter to the physician. A copy of the Physician Health Reporting Form and the letter to the physician are both placed in the physician's quality file. The physician is informed that he/she may write a letter of rebuttal, which is also placed in his/her quality file. If there are no further reports, no further action is required.

3. Tier Three

This is reserved for egregious activity (in which case Tiers One and/or Two may be skipped) or for repeated

episodes of minor dysfunctional activity. In this instance, the report is submitted both to the chief of the appropriate department and the Chief of Staff. This matter is discussed at the next regular (or called) meeting of the Physician Health Subcommittee of the Medical Executive Committee. The physician may or may not be invited to that meeting. After discussion by the full committee, a decision will be made regarding appropriate action (under the Bylaws) and whether to invite the physician to the next regular (or called) committee meeting. The physician will be informed that he/she may bring another physician of his choosing, with the understanding that this second physician must be a member of the medical staff and also be acceptable to the Physician Health Subcommittee of the Medical Executive Committee. The Physician Health Subcommittee of the Medical Executive Committee will determine what action is to be taken under the Bylaws and the matter will be reported to the Medical Executive Committee at its next regular (or called) meeting.

DOCUMENTATION GUIDELINES

Documentation of perceived impaired function is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. The Physician Health Report Form documentation should include:

1. Date and time of the questionable activity.
2. The circumstances surrounding the situation.
3. A description of the occurrence limited to factual, objective language as much as possible.
4. The consequences, if any, of the activity as it relates to patient care or hospital operations.
5. Record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening.
6. Physician's response to grievance.

Documentation of all credible grievances related to physician impairment should be submitted to the Medical Staff Office. The Medical Staff Coordinator shall promptly notify the appropriate chief of service and Chief of Staff..

Authority to access the Physician Health Report Form files through the Medical Staff Coordinator is granted to those with responsibilities related to the assessment of patient care. Those granted access are: the Chief of Staff, the Chairman of the Credentials Committee, Chairman of the Quality Committee, the Chief of the Department (to members of his/her department), the individual physician (to his own). (*Note: these must be confirmed). **The Physician Health Report Form must be reviewed in the Medical Staff office. Documents cannot leave that office.** Confidentiality of physician records is protected under Tennessee Code Annotated 63-6-219, which states that the records, forms, and knowledge collected for and/or by individuals or committees assigned to professional review functions in a health care facility are confidential and are not public records and as such are not subject to court subpoena.

REHABILITATION

To the extent possible, issues of the physician impairment will be dealt with in a caring collegial manner using the Physician Health Subcommittee of the Medical Executive Committee (see definition) to the extent that is reasonable and does not compromise the delivery of patient care or the physician's well being. In those situations clearly not manageable by collegial intervention or in those situations in which the physician cannot be allowed to continue the practice of medicine because of fear of harm to patients, Hospital and medical staff leadership shall assist the physician in locating a suitable rehab program. The hospital shall not reinstate a physician until it is established that the physician has successfully completed a rehabilitation program in which the hospital has confidence.

REINSTATEMENT

When considering an impaired physician for reinstatement, the hospital and medical staff leadership must consider patient care to be paramount. Upon sufficient proof that a physician who has found to be suffering an impairment

has successfully completed rehabilitation, the hospital and medical staff may consider reinstating the physician to the medical staff.

The physician must authorize release of information to be given by the physician director of the rehabilitation program in which he/she participated. A letter from the physician attending the impaired physician documenting the recovering physician's participation in the program, his/her compliance with all the terms of the program, the nature and frequency of follow-up if appropriate, the opinion of the rehabilitation program positions regarding the success of the program in this individual physician's situation, and finally, the rehabilitation physician's opinion concerning the ability of the recovering physician to resume his/her medical practice and provide continuous competent care to patients.

The recovering physician must inform the hospital of the name and address of his or her primary-care physician and must authorize the physician to provide the hospital of information regarding his or her condition and/or continuing treatment. The hospital and medical staff reserve the right to request and opinion from another physician consultant of its choice.

Assuming all this information indicates that the physician is capable of resuming his or her practice, the recovering physician must identify physicians willing to assume responsibility for his/her patients in the event that he/she becomes unavailable or unable to care for them. Furthermore, the hospital and medical staff leadership shall require the physician to provide the hospital with periodic reports from his or her primary-care physician – for a period of time specified by the Physician Health Subcommittee of the Medical Executive Committee, the Chief Administrative Officer and the Chairman of the Credentials Committee -- stating that the recovering physician's ability to treat and care for patients is not impaired.

The department chair or physician appointed by the department chair will monitor the physician's clinical activities in the hospital. The Credentials Committee will determine the nature of this monitoring after reviewing all of the circumstances.

The final decision to reinstate a physician's privileges must be approved by the Chief Administrative Officer in consultation with the Chief of Staff, the Chairman of the Credentials Committee with input as needed from the Physician's Health Committee.

If the recovering physician was impaired because of the use of drugs or alcohol, the physician must agree to submit to alcohol or drug screening test at the request of a member of hospital management team (Chief Administrative Officer or House Supervisor if the incident occurs after hours) or physician officers (Chief of Service, Chief of Staff or Vice-Chief of Staff) if another physician or nurse suspects that the physician may be under the influence of drugs or alcohol again. Because of the implications of a relapse, this is reviewed according to the procedure outlined in Tier Three.

Confidentiality of physician records is protected under Tennessee Code Annotated 63-6-219, which states that the records, forms, and knowledge collected for and/or by individuals or committees assigned to professional review functions in a health care facility are confidential and are not public records and as such are not subject to court subpoena.

POLICY ON SEXUAL HARASSMENT INVOLVING A PHYSICIAN

WHEREAS, it has been and currently is the policy of the Methodist Medical Center of Oak Ridge (MMCOR) that sexual harassment of or by employees, patients, members of the Medical Staff, and others has no place and will not be tolerated at MMCOR;

WHEREAS, the federal Equal Employment Opportunity Commission has declared that sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Act of 1964 for which the employer may be held responsible even if the harassment is committed by a person who is not an employee of MMCOR.

NOW THEREFORE, the Board of Directors restates its policy that sexual harassment will not be tolerated and hereby directs the Chief Administrative Officer to see that appropriate steps are taken to communicate the Board's intent -- as expressed in the general MMCOR policy for employees and in this policy -- MMCOR's employees, patients, and Medical Staff members. Specifically, the Chief Administrator Officer shall make sure that all employees, patients, and members of the Medical Staff are aware of MMCOR's policy against sexual harassment and that adequate procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur within MMCOR and that prompt action is taken on all complaints that are made. Moreover, recognizing that it is ultimately the responsibility of the Board of Directors to provide a MMCOR environment free from sexual harassment, the Board shall take whatever action necessary to ensure such an environment, including preventing individuals who engage in sexually harassing conduct from entering MMCOR facilities.

Procedure to Investigate a Complaint of Sexual Harassment Involving a Physician

1. Reports of sexual harassment from physician, nurse, other MMCOR employee, or patient who observes or who has been a victim of sexual harassment shall be made in writing and signed by the person preparing the complaint. The complaint shall include a factual description of the incident, including quotations of any offending language used.
2. Any MMCOR employee report of sexual harassment involving a member of the Medical Staff shall be submitted to the employee's supervisor, who shall forward it to the Chief Administrative Officer, or other member of the Senior Administrative Team. If an employee's report of sexual harassment involves his or her supervisor, or if the report concerns conduct that the employee believes has been or will be condoned by the supervisor, the employee may submit the report directly to the Chief Administrative Officer.
3. All patient reports of sexual harassment involving a member of the Medical Staff, as well as reports by one Medical Staff member filed against another Medical Staff member, shall be submitted directly to the Chief Administrative Officer, or other members of the Senior Administrative Team.
4. The Chief Administrative Officer shall immediately notify the Chief of Staff upon receipt of a report complaining of sexual harassment. These individuals, or such other individuals who shall be designated by the Chief Administrative Officer, shall interview the individual who filed the report and, when possible, others who were present when the incident occurred.
5. After interviewing the individual who filed the report and others who were present, or receiving a report of such interviews, the Chief Administrative Officer and the Chief of the Medical Staff shall determine whether the report of sexual harassment is credible. If a determination is made that the complaint is credible, the Chief Administrative Officer and the Chief of the Medical Staff shall determine to handle the matter either on a formal basis, by referring the matter for a formal review pursuant to the Medical Staff Bylaws, or on an informal basis by scheduling a meeting with the individual who has allegedly engaged in the improper conduct.
6. If a verified complaint is handled on an informal basis, there shall be a meeting with the individual, which shall be attended by the Chief Administrative Officer and the Chief of the Medical Staff. At that meeting, the individual who has been alleged to have engaged in improper conduct shall be advised of the nature of the complaints and shall be given an opportunity to respond to the allegations raised. The identity of the complainants shall not be revealed at this time unless, in the direction of the Chief Administrative Officer and the Chief of the Medical Staff, they deem it appropriate to do so and the individual in question has been advised that any retaliation against the complaint will not be tolerated.
7. If, at the conclusion of this meeting, it is believed that the alleged improper conduct did in fact occur, MMCOR shall take appropriate corrective and/or preemptive action, which shall include, but not be limited to, any or all of the following:
 - a. The physician involved shall be informed that the improper conduct violates federal law and will not be tolerated by MMCOR.

- b. The physician involved shall be informed that the improper conduct must cease immediately and, if appropriate, an apology must be offered to the complaint involved.
 - c. MMCOR may determine that the physician involved is not permitted to enter the MMCOR for an appropriate period of time depending on the circumstances of the complaint.
 - d. The physician involved shall be informed that any further incidents of a similar nature will result in the individual not being permitted to enter MMCOR and the initiation of formal disciplinary action in accordance with the Medical Staff Bylaws.
 - e. Depending on the specific circumstance and the matters discussed during this meeting, the Chief Administrator Officer and the Chief of the Medical Staff may also determine to immediately initiate formal disciplinary action in accordance with the Medical Staff Bylaws.
8. Minutes shall be kept of the meeting.
9. If the individual has agreed to stop the improper conduct, the meeting shall be followed up with a formal letter of reprimand and admonition to be placed in his or her confidential file. This letter shall also set forth those additional actions, if any, that result from meeting.
10. If the individual refuses to agree to stop the conduct immediately, such refusal shall result in notice that he or she will not be permitted to enter MMCOR facilities until such agreement is obtained. Such exclusion is not a suspension of clinical privileges, even though the effect is the same. Rather, the action is taken because the MMCOR has no choice but to protect its employees and others on its premises from improper conduct.
11. Any further reports of harassment, after the individual has agreed to stop the improper conduct, shall result in an immediate review by the Chief Administrative Officer and Chief of the Medical Staff (or their designees). If the review results in a finding that further improper conduct took place, the physician shall be excluded from MMCOR and formal disciplinary action in accordance with the Medical Staff Bylaws shall be instituted. Should this action entitle the individual to request a hearing under the Bylaws, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

CONFIDENTIALITY POLICY

Methodist Medical Center Confidentiality Policy (In matters related to credentialing, peer review, due process under the medical staff bylaws.)

POLICY STATEMENT:

It is the intent of Methodist Medical Center to insure confidentiality with respect to all information related to medical staff credentialing, peer review processes and any medical staff committee discussions related to such processes. This policy governs all records maintained by MMC regarding individuals appointed to the hospital's medical staff, including records and minutes of all committees and departments, quality assurance files, and credentials and peer review files. Such files are maintained in the Medical Staff Office under direct observation or in a locked cabinet or within the the Outcomes Management Office under controlled access.

1. All peer review documents must be clearly marked: "Confidential pursuant to TCA 63-6-219."
2. Peer review records should not be duplicated, nor placed in any other hospital files other than those referenced above.
3. If copies are disseminated to committee members, a mechanism to retrieve and dispose of such copies must be enforced.
4. Peer review records or documents prepared for review by peer review committees should never be included in patient medical records.
5. Only documents of peer review committees that are established or authorized by the hospital or medical staff bylaws will be protected. Therefore, it should be clearly documented that any adhoc committee to conduct a particular investigation or review is acting on behalf of the hospital, and pursuant to the medical staff bylaws.
6. Any protection afforded by the Tennessee statute regarding medical staff peer review activities will be lost if confidentiality is not maintained.
7. This policy applies to members of medical staff committees, departments, and any other medical staff members or hospital employees who may attend meetings or who have access to committee reports, recommendations or minutes which address peer review matters.
8. Access to confidential files is limited to the following persons and conditions:
 - a) Chief of Staff and medical officers – any individual or committee files
 - b) Chiefs of service – individual or committee files related to the respective service
 - c) Chair and members of Credentials Committee – any individual or committee files
 - d) Administrator/CEO – or his designated representative
 - e) Surveyors, inspectors with a need to know as approved by chief of staff and administration and hospital attorney as appropriate, exs.: TJC surveyors, state licensing surveyors, etc.
 - f) Individual physicians seeking access to their personal confidential files during regular business hours, upon 24 hours advance notice, and in the presence of a medical staff officer or a designee of the Chief of Staff.
9. **CONTENTS OF INDIVIDUAL CREDENTIALS FILES AND COMMITTEE MINUTES/RECORDS:**

Staff application, clinical privileges, license validation, malpractice insurance verification, DEA number, Medical school diploma, Board certification(s), Reference letters, National Data Bank queries, re-appointment verification, general correspondence (ex. Queries from managed care organizations seeking to validate staff privileges), letter of acceptance to staff, Medicare/Champus acknowledgment statement.

10. **DELETIONS/CORRECTION OR ADDITIONS:** Deletions from confidential files are not permitted. Corrections or additions should be made according to the policies outlined for corrections or additions to the patient medical record.
11. **SANCTIONS:** The following sanctions may be invoked for breaches of the signed confidentiality agreement regarding peer review activities.
 - a) dismissal from committee assignments and/or medical staff office;
 - b) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);
 - c) disciplinary action as deemed appropriate by the MEC pursuant to the Hospital's Credentialing Policy; and/or
 - d) other appropriate legal action
12. **CONFIDENTIALITY AGREEMENT:** All medical staff officers, section chiefs, medical staff committee members (MD and non-MD that are involved in peer review activities), and administrative officers shall sign and comply fully with a confidentiality agreement. Copies of such agreements will be maintained in the medical staff office.

TELEMEDICINE

Definitions

TELEMEDICINE

“Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care from a distance.

“Telemedicine Privileges” means the authorization to prescribe, render a diagnosis or otherwise provide clinical treatment to a patient through the use of electronic communication or other communication technologies.

Telemedicine Privileges to be Offered

After considering the recommendations of the relevant department chiefs and the Credentials Committee, the Executive Committee (MEC) shall make a recommendation to the Board regarding the telemedicine privileges that should be offered.

Applicants for Telemedicine Privileges

In order for a request for telemedicine privileges to be processed, the physician must satisfy all eligibility criteria. All requests for telemedicine privileges shall be processed in the same manner as all other requests for clinical privileges. The Hospital may use credentialing information from the applicant's primary hospital.

Quality

Telemedicine practitioners must participate in a QI program acceptable to the MEC.

MEDICAL RECORDS (Revised June 2012)

Keeping / Completion of the Medical Record

I. Access to and Disclosure of Medical Records

Physicians shall access patient medical records and use and disclose the information contained in such records only to the extent allowed by applicable law and subject to the requirements and limitations placed on such access, use and disclosure imposed by the Hospital.

II. Content of Record

The attending physician in conjunction with the appropriate service shall be held responsible for a complete medical record on each patient.

All clinical entries in the patient's medical record shall be accurately timed, dated, authenticated, and legible. All entries in the medical record must be legible.

A minimum case record for a patient admitted to Inpatient or Observation status at this medical center shall include:

- Identification sheet
- Medical history
- Allergies to foods and medicines
- Legal status of patients receiving behavioral health services
- Emergency care, treatment, and services provided to the patient before his or her arrival, if any
- Reason for admission or care, treatment and services
- Diagnosis, diagnostic impression, or conditions
- Physical examination
- Doctor's orders ***Please note that Medicare requires all orders to be dated and timed***
- Consultation reports, if applicable
- Progress notes by authorized individuals
- Relevant observations
- All diagnostic and therapeutic procedures, tests and results
- Comprehensive pain assessment appropriate to the patient's condition
- Medications ordered, prescribed and administered, including the strength, dose, rate of administration, access site or route, and any adverse drug reaction
- Nursing notes
- Goals of treatment and treatment plan
- Response to care, treatment, and services provided
- Discharge summary when applicable (Refer to Section IV)
- Records of communication with the patient regarding care, treatment, and services.
- Any applicable patient-generated information, for example, information entered into the record over the Web or in pre-visit computer systems
- Evidence of known Advance Directives
- HIPAA documents
- Consents

Appropriate forms shall be completed for consultations, x-rays, operations, prenatal, delivery room record, newborn and any other forms that may be approved by the UR/HIM Committee and MEC.

A. Emergency department records must include the following:

- Identification sheet
- Time and means of arrival
- The reason for treatment or services
- The impression

- Results of all diagnostic testing
- Whether the patient left against medical advice
- Conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care, treatment, and services
- Notation that a copy of the record is available to the practitioner or medical organization providing follow-up care, treatment, and services.
- Signature of treating physician along with date and time of discharge
- HIPAA documents
- Consents

B. Outpatient procedure records must include the following:

- Identification sheet
- Operative Report
- Short term operative record
- Outpatient History and Physical
- Laboratory results
- Progress notes
- Anesthesia/Sedation record
- Discharge instructions to patient and family, including medications
- Procedure Consent form
- HIPAA documents

III. Content of History and Physical

A proper History and Physical examination for planned inpatient and 23 Hour Observation shall be dictated or written for all patients no greater than 30 days prior to admission or within 24 hours of admission. The inpatient H&P must be updated within 24 hours of admission, if not dictated at time of admission, or prior to surgery/procedure by an appropriately credentialed individual (whichever comes first: the 24 hours or the surgery/procedure).

An outpatient H&P must be updated immediately prior to surgery/procedure. The original H&P must be dictated or written no greater than 30 days prior to registration by an appropriately credentialed individual. The update to the H&P must be performed regardless of the time frame between dictation of the original H&P and the surgery/procedure.

The H&P must be complete, recorded and present on the chart prior to any surgery/procedure.

For emergent situations a brief handwritten note will suffice preoperatively with the exception that the complete H&P will be dictated or written immediately after surgery.

The H&P will include:

- Date and time of examination
- Chief complaint
- History of present illness, including such assessments as symptoms, pain and course of illness, and results of any diagnostic tests
- Past medical history
 - *current active medical/surgical problems that require treatment or monitoring
 - * Inactive significant med/surg problems that will not likely require treatment or monitoring during the visit
 - * current health care providers (e.g., PCP, cardiologist) as appropriate

- Family history as it relates to the present illness
- Social history as it relates to the present illness
- Allergies to food and drugs
- Current medications
- Review of major systems, please see Appendix A for guidance
- General physical exam
- Problem list/assessment
- Plan of treatment
- Attending MD signature, title, date

The attending physician will sign or co-sign all History and Physicals within 30 days of the patient's discharge. An H&P with components in "short form" (See Appendix B) is acceptable for those patients whose intended treatment course is in the Outpatient setting, provided all elements on the form are addressed or completed. In the event an Outpatient is unexpectedly converted to Inpatient or 23-Hour Observation, the MD will write or dictate an H&P at that time that is appropriate for Inpatient or Observation, including the reason for the decision to change the patient's status. 'Short form' H&Ps are not acceptable for patients whose post operative care is planned for the Inpatient or Observation setting. Utilization of 'short form' H&Ps for planned Inpatient stays will result in assignment of a chart deficiency. For obstetric patients, a copy of the pre-natal record will suffice as an H&P, provided the format complies with current ACOG guidelines. For C-section, a dictated H&P is required.

Following TJC guidelines, a History and Physical which is performed up to, or no more than 30 days, before admission may be utilized, provided it is updated to reflect the patient's status within 24 hours after admission or registration, but prior to any surgery or procedure requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis.

For a listing of suggested elements of Review of Systems, please see Appendix A.

IV. Content of Discharge Summary

A proper Discharge Summary shall be dictated or written on all hospital stays longer than 48 hours (or under 48 hours with problems/complications) and should briefly cover all pertinent aspects of the hospitalization. This should include the following:

- Admitting diagnosis
- Final diagnosis
- Reason for hospitalization
- All pertinent laboratory and x-ray findings
- Operations, procedures, care, treatment and services provided
- Consultations
- Hospital course
- Discharge medications
- Patient's condition at discharge
- Discharge instructions to patient and family
- Attending MD signature, title, date.

V. Content of Operative Reports

Complete Operative Reports are to be dictated immediately after surgery. An operative progress note should be entered into the record immediately after surgery to provide pertinent information for anyone required to care for the patient. This operative progress note should include, at the minimum, the following elements:

- Pre-operative diagnosis
- Post-operative diagnosis
- Name of primary surgeon and assistants
- Findings
- Technical equipment used
- Procedures performed and a description of each
- Specimens removed
- Postoperative diagnosis
- Estimated blood loss (not required for cardiopulmonary bypass procedures)
- Attending MD signature, title, date.

‘Immediately after surgery’ is defined as “upon completion of surgery, before the patient is transferred to the next level of care”. If the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.

VI. Pre and Post-Anesthesia Documentation

A pre-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient should include:

- Notation of anesthesia risk
- Anesthesia, drug and allergy history
- Any potential anesthesia problems identified
- Patient’s condition prior to induction of anesthesia

A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after surgery or a procedure requiring anesthesia services.

VII. Completion of Charts

The medical record is an important part of quality medical care. It documents events that can be critical to the future care of the patient. Timely completion of the medical record is therefore an essential part of a patient’s hospital confinement.

Timely entry of the chart into the electronic medical record system provides information that is critical to ongoing care. Therefore, charts may not be held on the nursing units past 7 PM.

Operative Notes are to be completed immediately following surgery. The remainder of the chart is expected to be completed by the time of discharge but no later than the timeframe listed below:

Type of Account	Completion Days
Inpatient/Observations	30
Emergency Department	30
Day Surgery	30
Ambulatory Clinics, i.e., Sleep, Pain Clinic and XRT	30

On the second Wednesday of each month, the Health Information Management Department will send a written initial notice to physicians with delinquent charts. All records will be considered delinquent at the time of the audit if they do not meet the following criteria:

1. The chart must be complete and all dictation present.
2. Please note that charts will be considered delinquent the day after surgery if the operative report has not been dictated.
3. Dictated reports must be signed within thirty (30) days from the date of discharge; verbal and telephone orders are to be co-signed within 48 hours by a medical staff member providing care for the

patient during this time period. However, if the hospital's read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, no later than fourteen (14) days after the date of the verbal order. For suspension purposes, 5 missing report signatures carry the same weight as one dictated report. For example, a physician's admitting privileges will be suspended for one missing report, but not for 4 or fewer missing signatures. However these missing signatures will 'carry over' and must be completed in order to avoid suspension of privileges the following month.

- A. Following notification on Wednesday, if all delinquent charts are not completed by 5:00 p.m. on the last day of the month, the individual shall forfeit their privileges of admitting elective patients to the hospital and/or performing elective surgeries or procedures. Privileges are defined as the medical/surgical service for which you have credentials to perform. Admission to a partner's service shall not be permitted to circumvent the restriction of admitting elective patients.

Dictation should be completed well in advance of the deadline to allow time for transcription, review, corrections and application of signatures. Reports are not considered complete until they are corrected and signed.

- B. Emergency admissions and surgeries will be allowed. For hospital based physicians, emergency is defined as the lack of any other physician to substitute for the physician with delinquent records. The suspension leading to action under Appendix I, Article II of the Medical Staff Bylaws still applies.
- C. Reinstatement of privileges will occur only upon completion of delinquent records.
- D. The MEC grants authority to the Director of Health Information Management to implement the following procedure when a physician fails to clear delinquent records.
 - 1. Health Information Management notifies the following departments of the physicians with restricted privileges: Administration, Chief of Staff, Vice Chief of Staff, Chairman of UR/HIM Committee, Admissions, Nursing, Surgery, Respiratory Therapy, Catheterization Lab, Radiology, Pain Clinic, GI & Bronch Lab, and Cardiac Diagnostics.
 - 2. A copy is also placed in the physician's credentials file. Patterns related to delinquent records are considered at the time of reappointment.
- E. If a physician is on the suspension list three (3) or more times in a calendar year (January 1 - December 31), automatic resignation from the Medical Staff will result, as stated in the Medical and Dental Staff Bylaws, Article II.
- F. The Chairman of UR/HIM Committee under the following circumstances may grant extension of the time permitted to complete records:
 - 1. In case of illness or family emergency lasting not more than two (2) weeks
- G. Physicians should complete delinquent medical records prior to planned vacations. Extension of the time to complete medical records may be granted under this circumstance once in a calendar year by the Chairman of the UR/HIM Committee only if the notification of delinquency was delivered while the physician was on vacation. Vacations are not considered an acceptable excuse for non-completion of medical records. In case of personal illness or other emergency that lasts more than 2 weeks, arrangements for completion of medical records should be made with your group practice or other acceptable individual.
- H. Automatic extensions are granted under the following circumstances:
 - 1. If a required dictation is re-assigned to another physician a twenty (20) day extension is allowed.
 - 2. If signatures are missed due to lack of clerical analysis of deficiency, a twenty (20) day extension is allowed.
 - 3. If signatures are missed by the physician, Medical Records will call and physician has two (2) working days to come back in and sign.
 - 4. If the physician notifies Health Information Management that specific data such as a pathology report, lab or x-ray, is missing that precludes dictation at the time he requested the record, a seven (7) day extension is allowed.

- I. Delinquent signatures may be completed by your partners/colleagues by signing on your behalf and annotating that they signed in your stead. Signing your covering physician's orders in a medical record is permitted.
- J. Dictation of medical records information is made available by phone or at convenient dictation stations throughout the hospital.
- K. Electronic passwords are not to be shared. The delegation of signing of documents by electronic signature is not permitted.
- L. If a rubber stamp is used to authenticate medical documents, it may only be used under the following condition: a rubber stamp with a printed name may be used to clarify a signature that might otherwise be illegible, for example:

John Smith, MD

Signature Date Time

No rubber stamp bearing an actual signature may be utilized. This regulation applies to both Inpatient and Outpatient charts and orders.

- M. Going on vacation is no excuse for not completing medical records. Charts should be completed on an ongoing basis so that accurate records are available for ongoing patient care.
- N. Personal illness or other emergency family situations may be grounds to delay the delinquency process, but only for a reasonable period of time (2 weeks).
- O. The use of the term "privileges", as defined by your hospital credentials is designed to level the playing field for hospital-based physicians. Some physicians with delinquent records do not admit to the hospital and therefore, simply denying admitting privileges is no incentive to complete the records.

VIII. Ownership of the Record

All records are the property of the medical center and shall not be taken from the building without a Subpoena Duces Tecum.

IX. Patient Readmission

If a patient is re-admitted within thirty (30) days, an addendum by an appropriately credentialed individual documenting any changes will suffice instead of an additional history and physical. The addendum must be signed or co-signed by the attending physician.

X. Dental Records

Patient of general dentists shall be admitted to the combined services of the dentist and a doctor of medicine on the active medical staff. The physician will be responsible for the preoperative History and Physical of the patient.

XI. Oral Surgeons and Pedodontists

Patients of an oral surgeon or pedodontist shall be admitted to this service. A preoperative History and Physical shall be done by a physician on the active medical staff, except for the oral surgeons approved by the Credentials Committee to complete their own History and Physicals. The oral surgeon or pedodontist shall be responsible for the dental History and Physical and completion of the medical record.

XII. Obstetrical Records

Obstetrical records shall contain a recorded prenatal history. This may be a duplicate of the physician's office record and be updated on admission.

Obstetrical patients requiring surgery shall have a current dictated history and physical. Uncomplicated deliveries do not require a discharge summary. The delivery record will replace the discharge summary.

XIII. Neonatal Records

For neonates without complications, a hand written discharge summary may be completed using the neonatal discharge a template.

Neonates that require transfer to a higher level of care will require a discharge/transfer summary.

XIV. Podiatry Records

The podiatrist shall be responsible, consistent with his/her delineated clinical privileges, for the podiatric care of the patient, and medical history and physical examination.

XV. Conversion to Electronic Format

Medical Records may be converted to electronic format and stored and retained in such format by the Hospital. The electronic version of any medical records which has been so converted shall be considered the official, permanent medical record for all purposes.

XVI. Inflammatory Remarks in the Medical Record

Physicians and other health care professionals who document in the medical record will refrain from writing or dictating inflammatory remarks. If such remarks are found in the medical record, referral will be made to the Chief of Service.

XVII. Acceptable and Unacceptable Abbreviations

All entries to the medical record will adhere to Methodist Medical Center policies regarding acceptable and unacceptable abbreviations.

Clinical Documentation by Qualified Participants in Professional Education Programs:

It is the policy of Methodist Medical Center 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.

All entries in the medical record must be signed, dated, and timed.

APPENDIX A

Review of Systems (ROS) – Subjective review of common symptoms in each major body system as voiced by the patient. Purpose is to identify problems the patient has not mentioned or that have been missed while discussing the HPI. Begins with open-ended questions about overall health, and then proceeds in organized fashion from ‘head to toe’. For any positive symptoms, consider the 7 Attributes or PQRST as well as the patient’s perspective.

General:

Usual weight, weight change, weakness, fever, fatigue.

Skin:

Rashes, lumps, sores, itching, dryness, changes in hair, nails, skin color.

Head:

Headache, dizziness, lightheadedness.

Eyes:

Vision, blurring, redness, tearing, discharge, glaucoma, cataracts, blind spots.

Ears:

Hearing, tinnitus, earache, discharge

Nose and sinuses:

Frequent colds, stuffiness, discharge, itching, hay fever, sinus trouble

Mouth & throat:

Dental problems, gum soreness/bleeding, mouth ulcers, sore throat, hoarseness, trouble chewing or swallowing

Neck:

Lumps, swollen lymph nodes, goiter, pain or stiffness in neck

Breasts:

Lumps, pain or discomfort, discharge, self-exam practices

Respiratory:

Cough sputum (color, quantity), hemoptysis, dyspnea, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis, last chest x-ray

Cardiac:

Chest pain or discomfort, jaw pain, MI, hypertension, heart murmurs, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema

Gastrointestinal:

Heartburn, ulcers, regurgitation, nausea, vomiting, (blood), indigestion, bowel habits, changes in regularity and/or color, size of stools, blood in stools, diarrhea, constipation, hemorrhoids. Abdominal pain, food intolerance, changes in appetite, excessive belching or gas. Jaundice, liver or gallbladder trouble, hepatitis.

Urinary:

Frequency, polyuria, nocturia, dysuria, urgency, hematuria, hesitancy, dribbling, incontinence, urinary retention, infections, kidney stones.

Genital:

Sexual interest/function, history of STD’s, exposure to HIV.

Male: Discharge or sores, testicular pain or masses

Female: Menstrual problems – regularity, dysmenorrhea, excessive bleeding, PMS, menopausal symptoms, post-menopausal bleeding, vaginal discharge, itching, birth control, pregnancies/abortions.

Peripheral Vascular:

Intermittent claudication, leg cramps, blood clots

Musculoskeletal:

Muscle or joint pain, stiffness, arthritis, gout, backache

Neurologic:

Fainting, blackout, seizures, weakness, paralysis, numbness, loss of sensation, tingling, tremors, involuntary movements, problems walking, strokes, transient ischemic attacks, etc.

Hematologic:

Anemia, easy bleed or bruising

Endocrine:

Thyroid problems – heat or cold intolerance, excessive sweating, voice changes. Diabetes – excessive thirst or hunger, polyuria. Addison/Cushing's disease.

Psychiatric:

Nervousness, tension irritability, sadness, insomnia, memory loss, hallucinations.

APPENDIX B

Services That DO Require H&P's

Any Sedated Procedure (including radiology)
Angiogram
Surgery
Any Procedure with implant of a device (i.e., pH probe)
Chemotherapy
Drug Infusion*
Heart Cath
pH Study
Blood Transfusion
Myelogram
Thoracentesis
Paracentesis

Services That DO NOT Require H&P's

Arthrogram
EEG
Esophageal Motility Study
Rectal Motility Study
Labor Check
Manometry
Lumbar Puncture (if no sedation)
Q-Port Flush
Tilt Table Test
IV Infusion (no drugs)
Phlebotomy
Breast Biopsy if no sedation

* Stable patients receiving Remicade or IVIG infusions on a regular basis require a History and Physical once a year*

APPENDIX C

METHODIST MEDICAL CENTER

Outpatient Pre op / Pre procedure

History and Physical (page 1)

Name: _____

DOB: ____/____/____

MRN: _____

Chief Complaint: _____

Date: _____

History:

Review of Systems:

Respiratory: No current wheezing, cough, or shortness of breath

Cardiac: no current chest pain, palpitations, or lower extremity swelling

Any abnormal system: _____

Past Medical History: None

Past Surgical History: None

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

Allergies: NKDA _____

Medications: None

I reviewed today's medicine reconciliation list or medications are listed below:

Social/Family History: no smoking
 no etoh

smoker _____ppd
 drinks _____daily

Primary Care MD or Specialist MD: _____

INFECTION CONTROL

Obligations of the Medical Staff:

The physicians on the staff of Methodist Medical Center of Oak Ridge have the following responsibilities and obligations for Infection Control:

A. Handwashing: The hospital staff and physicians will perform hand hygiene tasks in compliance with the CDC/HICPAC Guidelines for Hand Hygiene in Health Care Settings. See attached policies, PIP I-14 and I-14A, for details.

B. Isolation: The physician shall appropriately isolate a patient according to the CDC/HICPAC Guidelines for Isolation Precautions in Hospitals. The medical staff, Infection Control manager, CMO, CNO, and infectious disease consultant have the authority to initiate or discontinue isolation precautions.

C. The physician shall inform Infection Control and/or Employee Health of MMC hospital staff and physicians with infections/exposures to communicable diseases. See attached policy, PIP I-12.2: Infection Control Measures for HCW's With or Exposed to Communicable Diseases, for details on follow-ups.

D. Physician/Employee Exposures to Blood/Body Fluid: The Infection Control Department, the Employee Health Department, and the Nursing House Supervisor have the authority to order the appropriate testing on the source patient. The attending physician of the source patient is notified of an employee exposure in the physician's progress notes. The attending physician shall notify the source patient of their test results. See attached policy, PIP I-11 Physician/Employee Blood/Body Fluid Exposure Reporting/Follow-up Process.

E. The physician shall inform Infection Control of **all** State of TN reportable diseases of patients and MMC hospital staff and physicians. See attached policy, IC-1: Reporting of Notifiable Diseases- Health Department, for a listing of reportable diseases.

F. The surgeon shall inform Infection Control of all post-operative wound infections through the monthly surgeon specific surgical site wound infection surveillance report.

G. The hospital staff and physicians shall comply with the mandates of the MMC Exposure Control Plan, which specifies the use of personnel protective equipment, work practice controls, and engineering controls to protect one's self from blood/body fluid exposures. See attached policy, PIP I-12 Exposure Control Plan, for specific details.

H. The hospital staff and physicians shall comply with MMC policies regarding sterilization and disinfection. See attached policy, PIP I-16 Event Related Sterility.

I. The physician shall comply with required orientation, periodic, and annual tests and vaccinations. Records which must be available include immune status to Rubella and measles, a record of HBV vaccination and immunity (or a declination statement), respirator fit testing, and an annual PPD skin test or evidence of review if a history of positive PPD is present.

PHYSICIAN NOTIFICATION OF SIGNIFICANT TRENDS OF INCREASED POST PROCEDURE INFECTION RATES

Purpose: To have a uniform, predictable, equitable method for handling quality trends over multiple reporting periods when identified. The Infection Control Committee shall determine the reporting periods. In addition, the Infection Control Committee shall determine those procedures for which rates will be determined on an individual basis as opposed to aggregate rate reporting.

I. A significant trend has been identified with a particular physician regarding their rate of post-procedure infections.

A. The Infection Control department identifies infections through review of culture results, surgeon specific self-reporting of post-op infections, physician feedback, and by notification from nursing, outcomes management and other personnel having knowledge of possible infection complications.

B. The definition of infection is uniformly applied by the Department of Infection Control.

C. The final decision of whether a case is an infection rests entirely with the Department of Infection Control and the hospital epidemiologist through the use of definitions and criteria based on CDC guidelines.

D. Unless denominator data is unavailable, all assessments of infection trends will utilize procedure specific rates.

E. Identified trends of MMC physicians and procedure specific rates will be compared to appropriate external benchmarks whenever possible for determination of significance.

II. The hospital epidemiologist or the Infection Control Committee Chairperson in collaboration with Infection Control personally notifies the physician in writing. Documentation of the findings will be kept in Infection Control. The cases in question are reviewed with the physician and questions answered. A process is initiated involving Infection Control and the designated physician to develop a plan of action to address the problem in a non-punitive manner.

III. Simultaneously, the chief of the service is notified. If the chief of the service is the physician of interest, then the chairman of the Medical Staff Continuous Quality Improvement (CQI) is notified. No action will be requested or taken at this time in the CQI committee. This action is for information only.

IV. Notification of the physician of interest and the chairperson is for accountability purposes only, not punitive.

V. If the rates of infection do not decrease in a subsequent period of time or the physician is unwilling to cooperate with the recommendations of an action plan, a request for review by the entire CQI committee is undertaken.

DIRECTOR OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). The director will be an active member of the medical staff with unrestricted privileges in anesthesia; of good reputation and character, including physical and mental health and emotional stability; and the ability to work harmoniously with others sufficiently so that the medical staff will be able to operate in an orderly and civil manner.