Parkwest Medical Center

Medical Staff Rules and Regulations

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PARKWEST MEDICAL CENTER STAFF RULES AND REGULATIONS
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Parkwest Medical Center

Medical Staff Rules and Regulations

I. GENERAL

1. **Upon appointment to the medical staff and as often thereafter as necessary, each member shall arrange for coverage by an alternate staff member for his/her patients in such member's absence. In the event the member cannot be reached within a reasonable period of time to manage an urgent problem, the alternate may be called in his place.**

2. **In the event of death occurring within the hospital, the attending physician will encourage performance of a postmortem examination in all cases other than those in which such examination would most likely fail to produce findings of any significant value. Under those circumstances, the attending physician will not necessarily seek permission for autopsy and will document the reasons for this decision within the discharge (death) summary.**

3. **Physicians shall have the privileges of admitting patients suffering from all types of diseases in accordance with the admissions policy adopted by the governing body. Patients will be admitted or treated by physicians who have submitted proper credentials and have been duly appointed to the membership of the staff or their qualified extender who is a member of the advanced practice professional staff acting under the supervision of the sponsoring physician.**

4. **Exclusion of certain clinical cases: The hospital shall admit patients suffering from all types of diseases.**

   Patients with tentative or confirmed diagnosis of certain communicable disease may be admitted to the isolation areas including private rooms designated by the admitting office.

5. **Procedures at all staff meetings are encouraged to follow Robert's rules of order.**

II. ADMISSIONS AND DISCHARGES

1. **Authority to admit patients is exclusively delegated to members of the medical staff and supervision of any and all treatment of patients is restricted to members of the medical staff. Patients admitted through the Emergency Care Center by emergency physicians shall be admitted to the service of an attending physician for continuity of care.**

2. **At the time of admission of a patient, the responsible physician shall provide the admitting clerk with any and all information necessary to insure protection of other patients and/or hospital employees from those who are a source of any danger whatsoever. The responsible physician shall also provide the admitting clerk with the provisional diagnosis, a statement whether the case is medical or surgical in nature, as well as the classification based upon the relative urgency of the condition for which admission is sought. All members of the medical staff shall comply with the medical staff approved regulations on temporary suspension of admission privileges and the "Admission Priority" policy. Compliance will include not admitting patients under practice associates' names while under suspension and adhering strictly to definitions of admission urgency in the Admission Priority policy.**

3. **On admission and during stay Practitioners shall provide:**

   (a) **The appropriateness and medical necessity of admissions and continued stay.**

   (b) **Supportive services.**

   (c) **Discharge planning.**

4. **Patients shall be discharged only on the order of a physician or by their qualified extender with prior attending approval provided the physician has seen the patient within 24 hours of the anticipated discharge. Routine discharges should be made by 11:00 a.m. daily whenever possible. The physician must co-sign extender's discharge note within 30 days following the patient's discharge (Rules & Regs, Section III, Medical Records, 1.).**

5. **Regarding patients admitted for abortion, said procedure shall comply with the state law and be consistent with good medical practice.**

6. **No minimum batteries of tests or examinations shall be required for any categories of patients. Standard orders for selected patients may be established by individual physicians.**

7. **Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information. This shall not be construed to require written consent for use of the medical record for automated data processing of designated information; for use in patients care evaluation studies, such as retrospective audit and medical staff monitoring functions; for departmental review of work performance; for official surveys for hospital compliance with accreditation, regulatory, and licensing standards; or for educational purposes and research programs. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.**

III. MEDICAL RECORDS AND DOCUMENTATION

1. **The attending physician shall be responsible for the preparation of a properly documented medical record for each patient admitted to his/her care. Prior to discharge of the patient, he/she will record the diagnosis justifying admission; as soon as possible thereafter, the physician or his qualified extender shall prepare and sign the discharge summary and insure that the chart is complete. The physician must co-sign extender's discharge note within 30 days following the patient's discharge (Rules & Regs, Section III, Medical Records 1.). In all cases, the medical record should be completed within thirty (30) days following the patient's discharge or it shall be considered delinquent.**

2. **A record of each patient's history and physical examination shall be written or dictated and placed in the patient's medical record within twenty-four (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 an outpatient basis.. The physical examination shall reflect a comprehensive current physical assessment. Medical history should be obtained from the patient, whenever possible. If a complete physical examination or history has been performed within thirty days of admission, such as in the physician staff member's office, a durable, legible copy of this report may be used in the patient's hospital**

medical record, provided there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. Upon admission, H&P's done within 30 days prior to admission must be marked as appropriate with either; no change marked, signed and dated or changes noted signed and dated. The recorded history and physical examination must be authenticated by a physician member of the medical staff.

Obstetrical medical records shall include all prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable, if current and updated within 30 days and may be substituted for the history and physical.

When other qualified individuals, to include but not limited to Physician Assistants and Nurse Practitioners, in accordance with State law and/or hospital policy have been approved for such duties as taking medical histories and documenting some aspects of a physical examination, such information is appropriately authenticated by the physician responsible for the patient.

Documentation of the medical history shall contain at least the following items:

- **chief complaint**
- **details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status**
- **relevant past, social, and family histories, including allergies**
- **pertinent review of body systems**

Documentation of the physical examination shall contain at least the following items:

- **General physical information**
- **Pertinent physical findings as indicated by patient complaints and complexity, such as dependent upon complaints and for procedures to be performed**
- **Conclusions or impressions drawn from the examination**
- **Course of action planned for the patient for the current treatment encounter**

3. **A SHORT FORM HISTORY is acceptable for short-stay surgeries, outpatient procedures, requiring moderate sedation, and for non-major oral surgeries. The content of the short-form history and physical shall contain:**

    1. **Chief Complaint/Present Illness**
    2. **Past Medical History**
    3. **Allergies**
    4. **Physical Examination, including at least the following:**
        - **General physical information**
        - **Pertinent physical findings as indicated by patient complaints and complexity, such as dependent upon complaints and for procedures to be performed**
        - **Conclusions or impressions drawn from the examination**
        - **Course of action planned for the patient for the current treatment encounter**

4. **Emergencies excepted, patients shall not be taken to the operating room and the operation shall be canceled unless a history and physical, or a brief handwritten admission note and evidence that a history and physical has been dictated appears in the medical chart.**

5. **Following a surgical operation/invasive procedure and prior to removal of the patient from the operating room or the recovery room, or procedure area, the surgeon/procedural list or his assistant should write or dictate a comprehensive operative report for the medical record. In addition, the surgeon/physician performing the procedure must write an immediate post operative progress note for the medical record, to include the name of the primary surgeon, name of assistant surgeons, medical findings; procedures performed; estimated blood loss, as indicated; specimens; and post-operative diagnosis; and any unusual events or complications.**

   To ensure continuity of care, physician should dictate Op Reports using the Covenant dictation system or system that can interface with our system within 24 hours of the procedure.

   Minimally invasive procedures as listed below do not require a history and physical. An immediate post-procedure progress note should be written to include at least the name of physician performing procedure, procedure performed and any other pertinent medical findings or events. Minimally invasive procedures are defined as all epidural steroid injections or diagnostic injections, nerve root blocks, sympathetic blocks, IV regional blocks, image guided biopsy, image guided drainage, image guided aspiration, myelograms, lumbar punctures, arthrocentesis, joint injections, central venous line or PICC placement, newborn circumcisions, pericentesis, thoracentesis, spinal tap, image guided tendon injection, epidural blood patch, interthecal chemotherapy injection and outpatient series or non-series electrolyte infusions, blood or blood product transfusions, iron infusions, and intravenous fluid infusions.

6. **A complete list of physician's incomplete medical records shall be mailed to the physician's office on the second Friday of each month.**

7. **On the fourth Monday of each month, a list of delinquent records is generated identifying each record and containing the expected completion date of the following Tuesday, allowing an eight (8) day period for the records to be completed. The list is faxed or emailed directly to the physician's office with the fax or email confirmation retained as proof of notice.**

8. **Failure to complete records within the time periods defined in above paragraph 7 – Physicians may continue to attend those patients already hospitalized under their care, but otherwise will be denied all admitting, consulting, obstetrical, and surgical privileges until the medical record delinquencies and/or deficiencies have been cleared. Admissions and scheduled procedures which have been scheduled prior to this date will be honored. A physician may not admit patients under the services of another physician when he/she is on the suspension list.**

9. **Without any further intervention and records remaining delinquent at noon (of the suspension day), the following department are notified:**

   Administration
   Admitting
   Bronch Lab
   Cardiac Cath Lab
   Chief of Staff

Day Surgery
Emergency Department
Endoscopy Lab
Outpatient Registration
Surgery
Urology Center

10. **The list of delinquent records requiring completion is verified each morning. As physicians complete the delinquent records, an updated suspension list is sent to the leadership and departments identified above.**

Once a physician has lost admitting privileges the second time in a calendar year Health Information Management will send out a certified letter, signed by the Chief of Staff or designee, reminding them if they are suspended a third time during the calendar year they will be referred to the Medical Executive Committee for possible loss of medical staff membership.

11. **No physician whose admitting privileges have been suspended because of delinquent medical records shall be denied admission of any patient to whom an Emergency classification may be properly assigned.**

12. **Upon request extensions may be granted by first the Chair of Medical Records or the Chief of Staff or the Chief of the Clinical Department for the following reasons:**

illness vacation extenuating circumstances

The Health Information Management Department must be notified by the individual granting the extension. Health Information Management will then notify the appropriate hospital departments of the extensions.

Note: No more than three extensions shall be granted to a physician in any twelve month period.

13. **The following incidents shall be referred, with documentation establishing that the incident has occurred, to the Medical Executive Committee. Upon determining that the documentation is sufficient to establish the occurrence of the incident, the Medical Executive Committee shall immediately take one of the actions authorized by the Medical Staff Bylaws, which shall be possible revocation of staff appointment. The "incidents" within this paragraph are the following:**

(a) **Failure to complete delinquent records while on suspension in excess of 30 days.**

(b) **A third suspension within a calendar year as described in paragraph 10 above.**

(c) **A first suspension for medical records delinquency that occurs after reappointment to the Medical Staff following revocation of staff appointment for medical records delinquency, provided all four events occur in the same calendar year.**

A physician, who is deemed to have resigned for the first time in his/her career under this section, may reapply immediately without condition. A physician, who is deemed to have resigned for the second time in his/her career under this section, may reapply for

appointment after three months, and only upon payment of $500 to the Medical Staff. A physician, who is deemed to have resigned for the third time in his/her career under this section, may reapply for appointment after three months, and only upon payment of $1,000 to the Medical Staff.

14. **All patient records shall remain the property of the hospital wherein the patient is treated and shall not be removed from that hospital except by court order, subpoena, or statute. In case of readmission of a patient or in the case of transfer of a patient to another hospital, all previous records or copies of appropriate portion thereof shall, regardless of ownership, be made available to the attending physicians whether the patient is attended by the same physician or another.**

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.

15. **Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the administrator, a physician may secure copies of medical records upon authorization by the patient.**

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. Physicians shall also prohibit their employees from accessing, using or disclosing information contained in any medical record in violation of applicable law or the requirements of the Hospital.

16. **No medical record shall be filed until it is complete, except on order of the Medical Executive Committee. No medical staff member shall be permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable permanently or protractedly for other reasons.**

17. **All clinical entries in the patient's medical record shall be accurately timed, dated, authenticated, and legible. Authentication means to establish authorship by written or electronic signature, identifiable initials, and computer key. The use of written or electronic signature, identifiable initials, computer key, and signature is acceptable under the following strict conditions.**

(a) **The practitioner, whose signature is represented, is the only one who has possession of such and is solely responsible for its use.**

(b) **The use of a rubber stamp is <u>only</u> acceptable under the following condition: A rubber stamp with a printed name may be used to <u>clarify</u> 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.

18. **A daily progress note will be recorded by the supervising physician or qualified extender. The supervising physician will have daily involvement with the patient's care, or more often as deemed clinically appropriate, or as requested by the patient or health care proxy. On days the patient is not seen by the physician, a statement will be entered in the medical record that the physician agrees with the plan of care.**

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

20. **A discharge summary (clinical resume) shall be written or dictated on all inpatients. The resume should recapitulate concisely the reason for hospitalization; significant findings; procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instructions given to the patient and/or family, particularly in relation to physical activity, medication, diet, follow-up care, and final diagnosis. The condition of the patient on discharge should be stated in terms that permit a measurable comparison with the condition of admission, avoiding the use of relative terminology such as "improved". When pre-printed instructions are given to the patient or family, the record should so indicate and a copy is retained in the record.**

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

22. **A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization.**

23. **It is the policy of Parkwest 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.

IV. CONSULTATIONS

1. **Consultation with other members of the medical staff shall be sought liberally and consistently with good medical practice.**

2. **If circumstances are such that the consulting physician determines that the consultation is not required for patient care, the consultation shall not be performed and the reasons therefore shall be entered in the progress notes of the clinical records.**

3. **Responsibility for Consultations: Maintenance of proper consultation standards is the responsibility of the respective departmental chairman, with the primary emphasis placed on periodic analysis of records.**

4. **A psychiatric consult must be requested for and offered to all patients admitted subsequent to an attempted suicide or chemical overdose, and this must be documented in the medical record.**

5. **All requests for consultations shall state the reasons for the consultation.**

6. **All requests for consultation shall state the time frame within which the consult should be accomplished. There are three (3) established time frames for consultations.**

    a) **STAT- generally responds to clinical situations within 3 hours or as determined through MD to MD communication.**

    b) **Routine – within 24 hours <u>unless</u> written as see today or see in a.m.**

    c) **As an outpatient**

7. **The ED Call Schedule will be utilized for ED call and in-house unattached patients.**

V. ORDERS, TREATMENTS AND MEDICATIONS

1. **All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a person qualified and authorized to accept such orders and if subsequently signed by the responsible physician. Persons considered to be qualified and authorized to accept orders related to their functions shall include R.N.'s, L.P.N.'s, Registered Pharmacists, Registered Physical Therapists, Registered Dieticians, Registered Respiratory Therapists, Speech Pathologists, Occupational Therapists, Physical Therapy Assistant, and Certified Occupational Therapy Assistant, Psychological Examiners, Psychologists, Recreational Therapists, Sleep/Neuro Techs. The above individuals will be limited to the scope of their licensure and training. All faxed orders are signed within 24 hours and/or replaced by the original order signed by the physician.**

2. **Transcription of orders dictated via telephone must be written down and read back. They shall include the name of dictating physicians, dentist or podiatrist, plus the name of the authorized person transcribing the orders.**

3. **Verbal Orders must be authenticated within 48 hours by the prescribing practitioner by dating, timing and signing; however, if the Parkwest Medical Center's read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, as promptly as possible but no later than fourteen (14) days after the date of the verbal order. To ensure timely authentication a partner, physician on call, or another responsible physician may choose to sign for the prescribing practitioner.**

4. **Stop-orders shall be applied to certain specified categories of drugs, and the nursing service is delegated the responsibility to notify attending physicians when such orders have been applied. Stop-orders are applicable to the following drugs:**

   (a) Injectable narcotics: Limited to seventy-two (72) hours.

   (b) Antibiotics: Limited to seventy-two (72) hours.

   (c) Digitalis preparations: (if given more than twice daily) limited to three (3) days except the physician may, by specific order, countermand the automatic stop-orders on this type of drug.

   (d) Anticoagulants: To be ordered for a specific dose to be given on a specific day or a specific number of days not to exceed ten (10) days.

   (e) IPBB treatments: Limited to five (5) days.

5. **Drugs used shall be those listed in the United States Pharmacopeia National Formulary, Physicians Desk Reference, with the exception of drugs for bona fide clinical investigations. Exceptions to this rule shall be well justified.**

VI. SELF PRESCRIBING AND TREATMENT FOR FAMILY MEMBERS

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 I prohibited**

Immediate Family

1. **Surgical or non-surgical treatment of immediate family members should be reserved only for 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 drugs**

VII. SURGICAL PROCEDURES: OPERATING ROOM

The following rules governing procedure and conduct in the operating rooms of Parkwest Medical Center have been assembled with one prime consideration -- the welfare of the surgical patient. All other considerations are secondary.

1. **Questions as to policies and procedures in the operating room in this hospital are under the jurisdiction of the Surgery Department. No charge in such policies or procedures are to be made without the authority of this Department.**

2. **No operating time or bed space shall be reserved or allotted to any physician, dentist or podiatrist except for specific case.**

3. **With the exception of emergencies, all surgical operations must have prior written consent of the patient or his legal representative.**

4. **The decision as to what constitutes an emergency is to be made by the attending surgeon scheduling the case and the head nurse in charge of the operating room. In case of disagreement between the two, the decision is to be made by the Chairman of the Surgery Department or if he cannot be reached, by the Chief of Staff or his designee.**

5. **Emergencies take priority over all other surgery at all times.**

6. **Operating room personnel will be so organized that one (1) operating room may be staffed and utilized in a reasonable period of time at any hour an emergency so justified.**

7. **Operating time may be forfeited on the authority of the Chairman of Surgery when the starting of the operation is delayed for more than fifteen (15) minutes by the absence of one or more of the essential members of the operating team. Surgeons are required to call the operating room if they anticipate being fifteen (15) minutes or more late; if the Chairman of Surgery is not present and available, the Operating Room Supervisor will determine an alternate time or forfeiture.**

8. **The preoperative diagnosis and contemplated surgical procedures shall be recorded prior to the commencement of any surgical operation.**

9. **All tissue surgically removed shall be submitted to a medical staff pathologist who shall make such examinations necessary to establish a pathological diagnosis. A list of exceptions approved by the Department of Surgery and Medical Executive Committee shall be kept on file by the Director of Laboratories and the Operating Room Supervisor. This list should be reviewed annually by the Department of Surgery and the Director of Laboratories.**

10. **The operating room surgeon and anesthetist are required to check their patient's identity before administering anesthesia and starting the operation. The circulating nurse is to confirm the patient's identity including hospital identification band before he enters the operating room.**

11. **No spinal anesthetic may be given unless there is a designated person other than the surgeon to watch the patient's condition. Such person may be anyone authorized by the surgeon to so act, but may not be any of the operating room nursing personnel.**

12. **Any patient who has had an operation under a conductive or general anesthesia shall go to the recovery room or to an area where recovery room services are provided.**

13. **No one is to enter an operating room during surgery without operating suit, cap and mask, or gown, cap and mask for observers, and conductive shoes or shoe covers.**

14. **Visitors in the operating rooms are to be kept to a minimum and restricted to those persons whose presence is expressly approved by both the operating surgeon and the acting O.R. Supervisor.**

15. **Infringements of these rules are to be reported by the operating room supervisor to the Chairman of the Surgery Department or the Administrator of the hospital. If the delinquency cannot be handled by them, then the matter is to be referred to the Medical Executive Committee.**

16. **Routine preoperative preps may be set up for various specialties, such as urology, neurosurgery, etc., when the majority of the surgeons on that service request it of the Surgery Department.**

17. **It shall be the responsibility of the operating room surgeon to have a qualified assistant in attendance during operations which in his judgment present unusual hazards to the patient.**

18. **The Operating Room Supervisor is obligated to notify a surgeon as soon as it becomes apparent that his case will be delayed more than ten (10) minutes past scheduled starting time.**

19. **There will be a pre-anesthesia evaluation of the patient by a physician, with appropriate documentation on the patient's medical record of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. Except in extreme emergency cases, this evaluation should be recorded prior to the patient's transfer to the anesthesia and operating area and before preoperative medication has been administered. While the choice of a specific anesthetic agent or technique may be left up to the individual administering the anesthesia, the pre-anesthesia medical record entry should at least refer to the use of general, spinal or other regional anesthesia. When other than anesthesia personnel are involved, reference in the medical record to the use of spinal, regional, topical, or local anesthesia should be made by the responsible physician or dentist when administered within the limits of his privileges. The pre-anesthesia record entry should include the patient's previous drug history, other anesthetic experiences, and any potential anesthetic problems.**

20. **Anesthesiology personnel will document at least one post-anesthesia visit to describe the presence or absence of anesthetic-related complications for each patient. When the visit and record entry by anesthesia personnel is not feasible because of early discharge, the attending physician is responsible for meeting this requirement.**

21. **Invasive procedures are defined as procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, caudal blocks, epidurals, arteriograms and implantations, and excluding venipuncture and intravenous therapy. Documentation of the need for the invasive procedure**

will be supplied by either the referring physician or the operating physician. The referring or operating physician will supply documentation of the need for the invasive procedure.

22. **To carry out the peer review duties of the Surgery Department of Article IV(B)(2) of the Medical Staff Bylaws, and to assist the Chair of the Surgery Department in his/her duties under Article IV(D)(4), (7) and (8) of the Medical Staff Bylaws, the Chair of the Surgery Department shall appoint and regularly convene a Surgical Quality Review Committee ("SQRC"), which shall be composed of representatives from each medical specialty using the operating room on a regular basis, whether within the Surgery Department or not. The SQRC, and its attendees, shall function as, and enjoy all of the privileges and immunities of medical peer review committees under state and federal law. The SQRC shall issue reports of its activities, findings and recommendations as the representative and delegate of the Surgery Department Chair, as provided in the Medical Staff Bylaws, to the Medical Executive Committee or the Medical Staff Quality Committee, as appropriate, in its sole discretion, for the type of activity, finding, or recommendation issued.**

VIII. EMERGENCY SERVICES

1. **The medical staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accordance with the hospital's basic plan for the delivery of such services.**

2. **An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record if such exists. The record shall include: (a) adequate patient identification: (b) information concerning the time of the patient's arrival, and by whom transported: (c) pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital; (d) description of significant clinical laboratory and roentgenologic findings; (e) diagnosis; (f) treatment given; (g) condition of the patient on discharge or transfer; and (h) final disposition, including instructions given to the patient and/or his family relative to necessary follow-up care.**

3. **Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.**

4. **There shall be periodic review of Emergency Room medical records by the physicians providing emergency medical services to evaluate quality of emergency medical care.**

5. **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 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.**

IX. SPECIAL SERVICES AND SUB-SPECIALTIES

1. **Should five (5) or more staff physicians of a recognized sub-specialty and/or common interest express a desire to form a section for the purpose of conducting regular meetings, the chairman of the appropriate department shall authorize the establishment of such a unit.**

2. **Dentists and podiatrists shall be required to have a physician member of the medical staff co-admit their patients. Anesthesiologists shall not have authority to co-admit any dental or podiatric patient.**

3. **A board eligible or board certified oral surgeon may evaluate patients by history and physical examination and shall be empowered to admit such patient without the necessity of a physician co-admitter, but only if this is one of the specific clinical privileges that has been granted to him. A physician member of the medical staff shall be consulted for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization and shall assist in determining the rise and effect of any proposed surgical procedure on the total health status of the patient.**

4. **Arrangements for admission shall be made by the dentist or podiatrist and the patient shall be admitted under his name together with the name of the physician responsible for the medical aspects of the case.**

5. **A patient admitted for dental care is a dual responsibility of the dentist and physician appointee of the Staff.**

(a) Dentist's responsibilities:

(1) **A detailed dental history justifying hospital admission.**

(2) **A detailed description of the examination of the oral cavity and a pre-operative diagnosis.**

(3) **A complete operative report, describing the findings and techniques. In case of extraction of teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination.**

(4) **The dentist is totally responsible for the oral or dental care.**

(5) **Progress notes as are pertinent to the oral condition.**

(6) **Discharge summary.**

(b) Physician's Responsibilities:

(1) **Medical history pertinent to the patient's general health**

(2) **A physical examination to determine the patient's condition prior to anesthesia and surgery.**

(3) **Availability to attend to the patient's general health status while hospitalized.**

(4) **Physicians are not responsible for any dental care or treatment of feet or consequences thereof.**

6. **A patient admitted for podiatry care is a dual responsibility involving the podiatrist and physician appointee of the staff.**

(a) Podiatrist's responsibilities

(1) The medical history pertinent to the patient's general health and the physical examination to determine the patient's condition prior to anesthesia and surgery may be performed by a podiatrist holding current privileges to do so. If the podiatrist is not privileged to perform the medical history and physical, an MD or DO will be responsible.

(2) A detailed history justifying hospital admission.

(3) A detailed description of the examination of the feet and preoperative diagnosis.

(4) A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.

(5) Progress notes.

(6) The podiatrist is solely responsible for the care of the feet.

(b) Physician's responsibilities:

(1) If the podiatrist does not hold privileges to perform the medical history and physical, a physician will be responsible for the medical history pertinent to the patient's general health and a physical examination to determine the patient's condition prior to anesthesia and surgery.

(2) Availability to attend to the patient's general health status while hospitalized.

(3) Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.

X. PHYSICIAN WELLNESS POLICY

Three or more members of the medical staff and/or hospital representative(s) will be appointed by the Medical Executive Committee to form the Physician Wellness Committee. The Physician Wellness Committee shall undertake to improve the quality of medical care by addressing both general and specific concerns of hospital health care practitioners who suffer from physical or mental impairment of their professional abilities, due to acute or chronic illness or injury. The Committee's proceedings concerning specifically identified hospital practitioners shall be confidential, and may not be discussed or disclosed outside of the Committee except by the referral and reporting procedures specified in these rules. The Committee shall operate in an advisory and referral role with the goal of rehabilitation of impaired practitioners, subject to the mandatory reporting required herein. The Committee shall carry out and encourage medical and hospital staff participation in the following Committee functions:

1. **To provide and promote general educational materials or programs to medical and hospital staff members, designed to enable and foster the prevention of impairment causing illness or injury; the self-recognition of practitioner impairment; and the recognition of signs of impairment in other practitioners providing medical care in the hospital.**
2. **To receive documented or verbally expressed concerns about a specific hospital practitioner's perceived impairment, either from the practitioner or from his or her hospital peers; to determine if such concern is sufficiently credible to warrant follow up by the Committee; to follow up said concerns with inquiries and/or recommendations to the affected practitioner, and with appropriate referrals to professional resources, in or out of the hospital, for the diagnosis and/or treatment of the perceived impairment; to monitor the course of any recommended diagnosis, treatment or training designed to confirm and/or rehabilitate the perceived impairment, by receiving and evaluating records and reports from the practitioner's health care providers, reports by the affected practitioner, and/or reports by his or her hospital peers, as the Committee may request; to question or counsel, on a confidential basis, either as a committee or through a designated committee representative, with the affected practitioner, at all stages of the**

Committee's processes; and, whenever possible, to close concerns that have been raised with a practitioner's perceived impairment by determining that said concern is not credible or substantial, and/or by providing follow up services, as referenced herein until the perceived impairment is resolved and/or rehabilitation is complete, and/or by obtaining the affected practitioner's voluntary assent to limit his or her practice in an appropriate manner.

3. **Whenever the Committee determines that a physician or other health care practitioner is providing unsafe treatment, it shall immediately report its determination to the Chief of Staff, who shall present the same to the Medical Executive Committee. The Chief of Staff may, if appropriate, exercise his authority under the precautionary suspension rules of these Bylaws, and the Medical Executive Committee may, if appropriate, exercise its authority to commence a formal, disciplinary investigation or action under these Bylaws, as if the matter had been referred to them by the Quality Committee.**

XI. INAPPROPRIATE BEHAVIOR POLICY

GENERAL POLICY OBJECTIVE

It is the policy of this Hospital 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. It is the objective of this Hospital to provide optimum care for Hospital patients and to prevent and eliminate inappropriate conduct that may disrupt Hospital operations and/or interfere with optimal patient care.

POLICY REQUIREMENTS

All health care practitioners and employees of health care practitioners exercising clinical privileges in this Hospital 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 of "inappropriate behavior" 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 "INAPPROPRIATE BEHAVIOR"

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

1. **Sexual or other harassment of an individual or individuals, meaning offensive behavior directed toward any individual or individuals that is based on race, color, religion, sex, pregnancy, national origin, age or disability.**
2. **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.**
3. **Threats of violence.**
4. **Carrying weapons.**
5. **Alcohol intoxication or use of any illegal drug or inappropriate use of controlled substances while on hospital property.**
6. **Inappropriate and disrespectful verbalization with respect to an individual or individuals.**

PROCEDURE

The procedure herein described envisions a three-tiered approach as follows: (1) the first grievance is dealt with in a collegial manner BUT a report of the meeting between the physician and his/her department chairman is placed 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 of behavior); in this instance both the chairman of the department and the Chief of Staff meet with the physician; a report is generated and is placed in the physician's quality file and the physician has the right to file a written rebuttal; (3) the third tier is used for either the first grievance of an episode felt to warrant bypassing of either the first two tiers and involves the (enlarged) Quality Committee and a report will be placed in the physician's Quality File; the physician has the right to file a written rebuttal. Information placed in a physician's Quality File remain until the time of his/her next reappointment at which time they may be destroyed unless, at the discretion of the Chief of Staff and then chairman of his/her department, such information is felt worthy of trending or otherwise preserving. Any decision to remove information placed in a physician's Quality File must be approved by a simple majority of the Quality 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 inappropriate physician behavior. Physicians will be notified whenever a grievance is filed against him/her. Employees should direct such concerns to their Manager, or House Supervisor, if the Manager is not available. Physicians should contact the Chairman of the appropriate Medical Staff Department. Concerns expressed by a patient or visitor should be directed to the Manager where the patient is receiving care, or the Hospital Patient Representative, who should in turn contact the Manager. The response process to perceived inappropriate physician behavior should be promptly initiated by the individuals designated above (Manager, House Supervisor, or Medical Staff Department Chairman). If the Medical Staff Coordinator becomes aware of any such behavior, the Medical Staff Office shall promptly contact the appropriate Medical Staff Department Chairman. 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. However, repeated instances of "inappropriate behavior" shall 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 "inappropriate behavior".

The "Unified Behavior Reporting Form" is to be used in all instances where inappropriate/disruptive behavior is reported, whether of or by members of the hospital or medical staff. Incident reports are not to

be used to report behavioral issues. Such reports filed by employees, patients, or family members are deposited in the office of the Chief Nurse Executive. Those submitted by members of the medical staff are deposited in the Medical Staff Office. In all instances, confidentiality is preserved.

1. Tier One

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 placed in the physician's Quality file. 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 following procedure is to be followed. If submitted by hospital staff, the Chief Nurse Executive is to receive the written report, if by the medical staff, to the chairman of the department. The Chief of Staff is then to be notified. The Chief of Staff along with the chairman of the appropriate department then meet with the physician. This meeting constitutes a more serious step than tier one. The physician is again reminded of his/her responsibilities and the specific behavior(s) and event(s) are discussed. A firm understanding must be assured by the physician re: his obligations not to engage in inappropriate behavior(s). This understanding is documented by letter to the physician and a copy of the report of the meeting 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 behavior (in which case tiers 1 and/or 2 may be skipped) or for repeated episodes of disruptive behavior. 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 Quality Committee. For the purposes of discussing behavioral issues, the Quality Committee will consist of the chair-elect of each clinical department plus the Chief of Staff, Chief of Staff-elect, the VP Operations of the Hospital, and the Chief Nurse Executive. 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 Quality Committee. The Quality 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 disruptive conduct is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. That documentation should include:

1. **Date and time of the questionable behavior;**

2. **If the behavior affected or involved a patient in any way, the name of the patient; filing a copy of the "Behavior Report Form" with Risk Management as well.**

3. **The circumstances which precipitated the situation;**

4. **A description of the questionable behavior limited to factual, objective language as much as possible;**

5. **The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;**

6. **Record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening.**

7. **Physician's response to grievance.**

Documentation of all credible grievances related to inappropriate behavior of physicians should be submitted to the Medical Staff Services Office. The Medical Staff Coordinator shall promptly notify the Medical Staff Department Chairman. In addition, documentation of any complaint of employee harassment (definition "1." of this policy) must be submitted to the Hospital's Human Resources Department.

XII. PHYSICIAN QUALITY FILES:

Policy: **Physician files are maintained on all physicians who practice at Parkwest Medical Center. These files contain quality data, peer review documentation, and other documents (i.e. copies of letters) as directed by the MEC or Quality Committee.**

Purpose: **Physician files provide information on the physician's clinical and/or technical skills as well as issues of conduct if appropriate. This information is used at the time of reappraisal for reappointment to the medical staff or renewal/revision of clinical privileges.**

Procedure:

1. **Physician profiles are located in the Quality Improvement Department. These files are locked at all times. The Director of Quality and Clinical Effectiveness is responsible for assuring that confidentiality and access are protected.**

2. **Authority to access the physician profiles 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), the Manager of the Clinical Effectiveness Department and Outcome Coordinators, Medical Staff Office Specialists.**

3. **Confidentiality of physician profiles 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.**

4. **Information contained in the files is directly related to the following review activities: monitoring and evaluation of patient care (important aspects of care, utilization review,**

focused reviews), surgical and invasive procedure review, medical record review, blood and blood products usage review, infection control review, actions taken as a result of inappropriate behavior, patterns or trends from complications screening, unanticipated event screening, mortality review.

Data reported (when available) as follows:

TJC Requirements

1. **<u>Blood and blood products utilization:</u> crossmatch to transfusion ratio, department crossmatch to transfusion ratio, committee review of blood product usage.**

2. **<u>Infection Rate for surgeons:</u> surgeons having performed Infection Control Surveyed procedures who have identified trends/patterns of Surgical Site Infections (SSI) will have attachments placed in the file as well as a notation on the Quality Data form. (Note: No physician specific infection rates will be recorded in the quality file).**

3. **<u>Pre-op/post-op/pathology discrepancies:</u> serious discrepancies will be reviewed and approved for inclusion by the appropriate department and Quality Committee before being placed in the physician's file. The discrepancy rate will be expressed as the number of discrepancies divided by the number of cases performed by the surgeon.**

4. **<u>Complications/unanticipated event monitoring:</u> number of complications/unanticipated events reviewed by the appropriate department/committee per quarter. Number requiring physician peer review that resulted in documentation placed in the quality file as directed by the MEC or Quality Committee per quarter.**

5. **<u>OB Data: c-section rates:</u>**

   primary rate = number of primary c-section/number of deliveries x 100%

   repeat rate = number of repeat c-sections/number of deliveries x 100%

   VBAC rate = number of successful VBACs/number attempted x 100%

   total deliveries (vaginal, c-section, VBAC), department c-section rates.

6. **<u>Actions taken as a result of the Inappropriate Behavior Policy</u>: documentation as directed by MEC, Quality Committee.**

7. **<u>Medical Records suspensions</u>: number of times the physician has been suspended from the active medical staff in the preceding calendar year**

8. **<u>Mortality</u>: Number of deaths during the preceding year for whom the physician was attending**

9. **<u>Autopsy:</u> Number of autopsies for the year, discrepancies in the final diagnosis and the autopsy diagnosis**

10. **<u>Risk Management</u>: events requiring root cause analysis in which the physician or his/her actions resulted in the unanticipated event**

11. **<u>Resource Management:</u> total admissions, total procedures, total consultations for the year**

12. **<u>Process and Quality Improvement Activities</u>: participation on hospital process improvement committee, served as Medical Staff Department/Committee officer, participation in JCAHO or other regulatory body survey, served as medical staff liaison, physician advisor or champion.**

XIII. PSYCHIATRIC SERVICES:

Recommend adding the following:

Psychiatric Services Delivered at Peninsula

1. **Peninsula Hospital provides assessments for scheduled appointments and walk-in clients to assist these individuals in identifying the most appropriate treatment and services. Assessments are performed through both face-to-face and video conference interviews with competent clinical staff members. The medical staff have designated that a Peninsula Hospital, the following clinical staff members, after proper training and through on-going supervision, may complete the emergent crisis intervention assessments:**

- **Physicians**
- **Psychologists**
- **Licensed or Masters Level Therapists**
- **Registered Nurses**
- **Bachelors Prepared Case Managers**
- **Bachelors Prepared Program Counselor Team Leaders**
- **Mobil Crisis Unit Staff Members**

2. **All patients at Peninsula Hospital must be seen by a physician a minimum six (6) day a week unless seventh (7th) day is clinically indicated and specifically requested by clinical staff and/or is specified through a third party payor contract.**

3. **Patients in the residential and outpatient levels of care shall receive the number of visits by appropriate medical clinical staff as indicated by medical necessity or regulatory requirements for particular level of care.**

4. **It is the responsibility of the supervising physicians (with input from nurse practitioners) to establish written protocols that outline in the residential and outpatient levels of care to establish written protocols that outline the scope of practice for the nurse practitioner and both parties will sign the protocols. It is the responsibility of both parties to be familiar with the ensure compliance with state Board of Nursing and Board of Medical Examiners regulations governing the supervision of nurse practitioners.**

5. **Nurse practitioner in the residential and outpatient levels of care may prescribe medications as long as prescribing practices are consistent with written protocols and within the nurse practitioner's scope of practice as defined by state regulations.**

6. **Admission of a patient to the residential level of care will be made by a physician member of the medical staff or a properly credentialed professional, unless otherwise specified by a third party payor contract. These professional are permitted to perform the initial psychiatric evaluation and to write admission orders. All medial and psychiatric are will be directed by a physician or a nurse practitioner.**

7. **Psychological assessment, treatment planning, and delivery of psychological care for patients in the residential level of care will be under the direction of a doctoral level clinical psychologist and will be delivered in accordance to the multi-disciplinary treatment plan.**

8. **For the residential level of care, seclusion/restraint orders can be given by a physician, a properly credentialed nurse practitioner, or a doctoral level clinical psychologist.**

9. **Admission of a patient to the outpatient level of care will be made by a physician member of the medical staff or a properly credentialed psychologist, nurse practitioner, or master's level mental health therapist. If such professional are not licensed supervision will be provided by a licensed mental health professional. Any of these professional may conduct the initial assessment and indicate a preliminary diagnosis. In programs that include medical services, the responsibility for treatment planning and continued diagnosis will be transferred to a physician or nurse practitioner in that program upon the physician's first visit with the patient. In psychosocial and other programs that do not include medical services, patients may be admitted by any staff member permitted by state licensure regulations and payor requirements. The only exception to this section will be the Partial Hospitalization Program that requires admission, assessment, and diagnosis by a physician only.**

10. **For patients in the residential level of care, a history and physician examination will be completed within one (1) week of admission. The physical examination shall reflect a comprehensive current physical examination and the medical history should be obtained from the patient and parent/guardian whenever possible.**

11. **For patients in the outpatient level of care, a physical health screening will be completed upon admission into the program. The physical health screening will be used to determine I\if further physical assessment is needed.**

12. **For medical records in the outpatient level of care (traditional outpatient only), the record is considered closed upon 90 days of no treatment contact wit the patient and the patient is discharged from the program. The final physician or nurse practitioner entry services as the clinical conclusion of the case and no discharge summary is necessary.**

XIV. 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.