FORT LOUDOUN MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

Lenoir City, Tennessee

Fort Loudoun Medical Center
Medical Staff
Rules and Regulations

Revisions:
August 2007
May 2008
June 2008
September 2008
November 2008
August 2009
October 2009
June 21, 2010
August 2012
September 2019

TABLE OF CONTENTS

RULES AND REGULATIONS
OF
THE MEDICAL STAFF
OF
FORT LOUDOUN MEDICAL CENTER

GENERAL

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 members 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.

I ADMISSION AND DISCHARGE OF PATIENTS

A. A patient may be admitted to this Hospital only by members of the Medical Staff. The admitting Staff member shall be considered the attending Staff member. The attending physician is responsible to ensure the patient is seen every twenty-four (24) hours by the appropriate physician. No patient will be admitted without a provisional admission diagnosis. The attending Staff member's name shall appear on the record summary. The attending Staff member is responsible for the care of the patient, unless otherwise documented in the physician's orders (i.e., transfer of service or coverage during the attending physician's absence). The attending Staff member or responsible practice group member involved in the majority of the care of the patient will be responsible for completion of the medical record including the diagnosis validation and the discharge summary.

B. Patients admitted to the Hospital shall be the responsibility of the admitting Staff member or another authorized practitioner. Such practitioner shall be responsible for the medical care and treatment, for the completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of condition of the patient to the referring physician and to relatives. Whenever these responsibilities are transferred from one member of the Staff to another, a note to that effect shall be made on the patient's record.

C. The admission policy is nondiscriminatory. All medically indigent patients shall be admitted by members of the attending Staff, and shall be assigned to the services concerned in treatment of the disease which necessitates admission or treatment. Transfer between the various services may be made in accordance with the judgment of the attending physician on service.

D. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and Hospital personnel. Administrative Policy PC.ED.001 – Duty to Furnish Hospital Services

E. Patients shall be discharged only by orders of the attending physician, or designated responsible physician. The final diagnosis shall be entered on the chart by the physician within the guidelines of the medical record number reference or approved discharge criteria, except when the diagnosis is unclear due to pending pathology specimen or diagnostic study results. When patients leave against medical advice, the policy for Discharge Against Medical Advice will be followed.

F. Upon expiration of a patient, the deceased shall be pronounced dead by his attending physician, or the designated physician on call, within a reasonable time.

The physician responsible for the care of the patient shall be responsible for signing the Death Certificate.

No autopsy shall be performed without signed, written consent of the proper relative, or other persons authorized by law to order autopsies.

G. Guidelines for Organ/Tissue Donation at FLMC are defined to assure the option of organ/tissue donation is provided to the next-of-kin of all potential donors and that FLMC is in compliance with Tennessee State Law 1140 and the Omnibus Act P.L.99-509. Reference Administrative Policy pC.NU.015 – Organ and Tissue Recovery

II. MEDICAL RECORDS

A. The Keeping of the Record

1. The attending physician shall be responsible for the preparation of a complete legible medical record for each patient.

2. The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record contains at least the following:

The patient's name, sex, address, date of birth, and the name of any legally authorized representative, allergies to foods and medicines, the patient’s language and communication needs.

Records of communication with the patient regarding care, treatment, and services, (for example telephone calls or email).

Patient-generated information (for example, information entered into the record over the Web or in previsit computer systems)

The patient's legal status, for patients receiving mental health services;

Emergency care provided to the patient prior to arrival if any;

The record and findings of the patient's assessment;

A statement of the conclusions or impressions drawn from the medical history and physical examination;

The diagnosis or diagnostic impression;

The reason(s) for admission or treatment;

The goals of treatment and the treatment plan;

Evidence of known advance directives;

Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy;

Diagnostic and therapeutic orders, if any;

All diagnostic and therapeutic procedures and tests performed and the results;

All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;

Progress notes made by the medical staff and other authorized individuals;

All reassessments, when necessary;

Clinical observations;

The response to the care provided;

Reports of all consultations provided;

Every medication ordered or prescribed for an inpatient;

Every dose of medication administered and any adverse drug reaction;

Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;

All relevant diagnoses established during the course of care; and

Any referrals/communications made to external or internal care providers and to community agencies.

3. All patient records 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. All records are property of the hospital.

4. Free access to all medical records of all patients shall be afforded to medical staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients.

5. When a patient presents for treatment as an inpatient or an outpatient, all previous medical records are available and assembled upon request for the treating physician(s).

6. It is the policy of Fort Loudoun 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.
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.

B. Content of the Medical Record

1. Although the format and forms for use in the medical record will vary, all medical records contain the following:

- identification data (when identification data are not obtainable, the reason is documented in the record)

- medical history

- reports of relevant physical examinations -

diagnostic and therapeutic orders

- evidence of appropriate informed consent (when consent is not obtainable, the reason is documented in the record)

- clinical observations, including the results of therapy

- reports of procedures, tests, and the corresponding results

- conclusions at termination of hospitalization or evaluation/treatment

2. The member of medical staff admitting a patient must assure that a complete and current medical history and a complete and current physical examination of the patient are carried out by a member with

unlimited, independent privileges at this hospital. To be current, the history and physical must be carried out no more than 30 days before the admission, or within 24 hours after admission, or registration, and in any event, prior to any surgery or procedure requiring anesthesia services. If the history and physical were completed before the admission, they must be updated, by a member with unlimited, independent privileges at this hospital to include an examination for changes in the patient's condition, within 24 hours after the admission or registration or prior to any surgery or procedure requiring anesthesia services. Documentation of the history and physical, completed and updated as required herein, must be placed in the patient's chart prior to the procedure requiring anesthesia services.

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

3. 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.

4. A thorough physical examination shall be written or dictated by the responsible physician for all patients within 24 hours of admission. If a complete physical examination has been performed within 30 days prior to admission, a durable copy of this report may be used in the patient's medical record provided an addendum indicating either appropriate changes or a statement of no change at the time of admission is included. Any such addendum must be done within 24 hours after admission or registration but prior to surgery or other procedure requiring anesthesia regardless of whether care is being provided on an inpatient or outpatient basis. Documentation of the physical examination shall contain the pertinent information from an appropriate list of the following items:

- head, eyes, ears, nose, throat
- respiratory
- cardiovascular
- gastrointestinal
- genitourinary
- central nervous system
- musculoskeletal
- conclusions or impressions drawn from the examination
- course of action planned for the patient for the current treatment encounter

5. The history and physical must be authenticated by a member of the medical staff. When other qualified individuals 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.

Whenever there is a delay in transcribing of the History and Physical is not present, an admission note is necessary. The medical record should include a brief description of:

- Signs and Symptoms
- Heart Rate
- Respiration Rate
- Blood Pressure
- Plan of Care

6. With the exception of emergencies, patients shall not be taken to the operating room unless a history and physical, or a brief hand- written admission note and evidence that a history and physical has been dictated, appears on the chart.

7. History and physical criteria may be met utilizing any of the following:

- a consultation supplementing areas not covered in the attending physician's history and physical

- a consultation providing a complete history and physical

- a copy of a history and physical completed in the physician's office can utilized if it has been completed within 30 days from the admission date, and includes an addendum indicating changes. Any such addendum must be updated within 24 hours after admission or registration but prior to surgery or other procedure requiring anesthesia regardless of whether care is being provided on an inpatient or outpatient basis.

In all instances, the timeliness requirement is the same as that for a History and Physical. For a consultation to be considered as a history and physical for a surgery patient, it must be on the chart prior to surgery.

8. The medical staff defines the scope of an appropriate assessment for invasive procedures. 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, mylograms and intravenous therapy.

9. Outpatient Procedures – The history and physicial exam at a minimum, will include:
   - History of Chief Complaint
   - Physicial Exam of relative body systems to include Cardiac and Pulmonary examinations
   - Impressions and Conclusions
   - Plan of treatment

10. Diagnostic and therapeutic orders shall be written in ink or typewritten and shall be dated and signed. All orders shall be written clearly, legibly, and completely. Registred Nurses and Licensed Practical Nurses shall be authorized to take verbal orders of a general nature. Other persons, such as, but not necessarily limited to:

    Physical Therapist
    Occupational Therapist Respiratory
    Technologist Speech Therapist
    Pharmacist
    Radiology Technologist

UltraSonographers Nuclear
Technologist Dietitian
Sleep Techs
Neuro Techs

may take only orders limited to their specific license, training and experience. All orders, including verbal orders, must be dated, timed, and authenticated by the ordering physician. All verbal orders are to be authenticated by the practitioner responsible for the patient 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. All faxed orders are signed within 24 hours and/or replaced by the original order signed by the physician. Those individuals authorized to submit an order for laboratory testing shall include a duly licensed physician, dentist, or other healthcare professional legally permitted to submit such orders. "Other healthcare professionals" include, but are not limited to, Nurse Practitioners and Physician Assistants under their approved protocols.

Protocols or standing orders, applying to all patients or to groups of patients, may be developed by the requesting physician(s), the appropriate staff committee, and administration. Once developed, unit- wide or department-wide standing orders shall be brought to a vote by the staff, published by administration, and may not be changed except by the mutual consent of the medical staff and administration, with administration notifying all concerned parties. Standing orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician, they shall constitute the orders for treatment. Standing orders shall not replace or cancel specific orders for any patient.

Schedule II drugs and systemic antibiotics that are ordered without time limitations shall be flagged for order determination after seven days by a reorder sticker appearing on the chart. No drug order will be discontinued without an order being received from the physician.

11. Informed consents are required before medical treatments, diagnostic studies, investigational drugs, each surgical or invasive procedure, blood transfusion, or administration of anesthesia on all patients except in the case of emergency. Informed consents shall be signed by the patient or his/her legal guardian. In the case of emergencies involving a minor or an unconscious patient in which consent cannot be obtained from a parent, guardian, or next of kin, the circumstances shall be fully documented in the patient's medical record. A written permit for sterilization shall be signed by the patient for operative sterilizations for any male or female.

Written consent is required from the legal next of kin prior to initiation of an autopsy. Legal next of kin, by priority are:

a) Spouse
b) Adult son or daughter
c) Either parent
d) Adult brother or sister
e) Either grandparent
f) Legal guardian
g) Any other person authorized or under obligation to dispose of the body

12. Progress notes must be recorded by a physician at least every 48 hours and shall denote the patient's status, frequency and detail of changes, and the condition of the patient. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

Patients in either 23 or 48 hour observation status will be visited at least once during the observation period by the physician with an appropriate notation made in the medical record.

13. Consultation reports contain a written or dictated and authenticated opinion by the consultant that reflects, when appropriate, an actual examination of the patient and a review of the patient's medical record.

14. Operative reports must be written or dictated immediately after surgical or invasive procedures and before the patient is transferred to the next level of care. The report should include the following information:

- Date of the procedure
- Preoperative diagnoses
- Postoperative diagnoses
- The name of the surgeon(s) who performed the procedure and any assistants
- The name/description of the procedure(s) performed
- A description of the findings, the technical procedures used,
- Any specimens removed,
- Any estimated blood loss,
- Complications, if any
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any

The complete operative report is filed in the medical record as soon as possible after surgery and is authenticated (by signature, computer key, or electronically by the originating physician.

When a full operative or other high-risk procedure report cannot be entered immediately into the record after the procedure, a progress note is entered in the record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, any estimated blood loss, any specimens removed, postoperative diagnosis, and complications, if any.

Note: If the full operative/procedure report is created and signed immediately after the procedure, using front end transcription, the immediate post-op note (aka Brief Op Note) is not required.

15. Reports of pathology, clinical laboratory, imaging services, and anesthesia services are completed promptly and are filed in the record within 24 hours of completion, if possible. An autopsy report documenting the provisional anatomic diagnosis shall be completed within three days of expiration. The final autopsy report shall be completed and filed in the record within 60 days of expiration if no brain tissue was submitted for analysis. Analysis of brain tissue may cause the report not to be available for four months.

16. The attending surgeon will be responsible for evaluating the patient as to the patient's need for surgery and anesthesia. Once this evaluation is made and recorded in the medical record, a pre-anesthesia evaluation will 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.

The Anesthetist will choose the appropriate anesthesia plan of care in accordance with the AANA guidelines published by that organization.

The post anesthetic assessment shall be documented by a physician or a nurse anesthetist qualified to administer anesthesia and must document the presence or absence of anesthesia-related complications and must include the date and the time of the visit. The post-anesthesia evaluation must be performed after the patient's completed recovery from the anesthesia and shall take place no later than 48 hours following the procedure.

17. A discharge summary shall be written or dictated on all hospital medical records within 30 days after discharge of the patient and within 24 hours of discharge if the patient is transferred to another facility. The discharge summary should concisely recapitulate the reason for hospitalization and include the following elements:

- Reason for admission (chief complaint and diagnoses) - Principal diagnosis

- Secondary diagnosis including complications and co morbidity - All operative procedures performed

- Pertinent laboratory, radiology, and physical findings - Medical and/or surgical treatment

- Condition on discharge (stated in terms that permit a measurable comparison with the condition on admission, avoiding the use of relative terminology such as "improved")

- Instructions on continuing care given to patient or responsible party, including medications, diet, physical activity, and follow- up care

- Final diagnosis without use of abbreviations or symbols

18. When preprinted instructions are given to the patient or responsible party, the record so indicates and a copy is retained in the record

19. 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. The final progress note includes discharge instructions given to the patient or responsible party.

20. All clinical entries in the patient's medical record shall be accurately timed, dated and authenticated (by written signature, identifiable initials, or computer key.) All other entries shall be dated and authenticated 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.

21. A list of acceptable abbreviations and symbols approved by the medical staff is maintained with the explanatory legend and is made available to those authorized to make entries in the medical record and those who must interpret records. The official list of approved abbreviations and symbols is reviewed annually, revised as necessary, and kept on file in the Administrative Policy and Procedure manual. Each abbreviation and symbol approved must have only one meaning.

"Do Not Use" Abbreviations include:

Abbreviation	Preferred Term
U (for unit)	Write "unit"
IU (for international unit)	Write "international unit"

Q.D. (once daily) Q.O.D. (every other day)	Write “daily” and “every other day”
Trailing zero (3.0 mg) Lack of leading zero (.3 mg)	Never write a zero by itself after a Decimal point (3 mg) and always Use a zero before a decimal point (0.3 mg)
MS MSO4 MgSO4	Write “morphine sulfate” or “magnesium sulfate”
T .I .W. (three times weekly)	Write “three times weekly”
cc (cubic centimeters)	Write “ml” for milliliter
uq (micrograms)	Write “mcg”

C. Timeliness

1. In all cases the medical record shall be completed within 30 days following the patient’s discharge or it shall be incomplete and the physician subject to the suspension process. Medical records which do not contain any one of the following within 30 days of the patient’s discharge shall be considered delinquent and the responsible physician will be placed on suspension until such delinquencies are resolved:

   Authenticated History and Physical
   Authenticated Operative Report (if applicable)
   Authenticated Consultation Report (if applicable)
   Authenticated Discharge Summary

2. The list of physician's incomplete records will be reviewed at least every 7 days to determine if the physician has any records that are 21 days post discharge. A preliminary list will be compiled and these physicians will *receive notification by certified mail of suspension if the records are not completed at 30 days* post discharge.

   Physicians will give the Health Information Management Department no less than thirty (30) minutes notice when they will arrive to complete their records; and, will be responsible for completing ALL available records.

3. Failure to complete records within the time periods defined in paragraph 1 above will result in the automatic suspension of all clinical and admitting privileges. Admissions and scheduled procedures which have been pre-registered will be honored. A physician on suspension may not schedule, treat, or admit patients. This does not apply to emergency situations. A physician may not admit patients under the services of another physician or perform surgical or other invasive procedures when he/she is on the suspension list. Reinstatement of these privileges is allowed immediately upon completion of all available delinquent

record(s).

4. The suspension list will be distributed to the following areas/departments by Health Information Management:

Administration
Case Management
Central Scheduling
Chief of Staff
Day Surgery
Emergency Department
Endoscopy Lab
Medical Staff Office Outpatient
Registration
Pre-admission Testing
Registration
Surgery

5. Any physician with three (3) three suspensions with a calendar year will constitute a request for voluntary resignation of medical staff membership.

Once a physician has lost admitting privileges the second time in a calendar year, Health Information Management will send a certified letter, signed by the Chief of Staff or designee, reminding him/her if he/she is suspended a third time during the calendar year he/she will be considered to have voluntarily resigned medical staff membership pursuant to paragraph 6 above. After reapplication and reinstatement each subsequent suspension, within the same calendar year, may also result in similar action, i.e., referral to the MEC, and possible loss of medical staff membership.

6. 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.

III. QUALITY IMPROVEMENT/PEER REVIEW

A. System Quality Improvement and Professional Relations Committee of the Board has the authority:

1. To act on behalf of the Board of Directors with respect to routine credentialing matters: recommendations of medical staff appointments, revision of clinical privileges, and termination of appointments, subject to the provisions set out in the Medical Staff Bylaws.

2. To review, monitor and approve the quality of care and quality improvement programs, procedures and mechanisms.

3. To review the quality of patient care services provided by the system and its medical staff as part of the program to assess and improve quality, to include those physicians who are medical staff members but who do not have an inpatient hospital practice.

4. To review, monitor and approve safety and risk management policies and procedures.

5. To assist the board of directors in implementation of the peer review process consistent with the Medical Staff Bylaws.

6. To facilitate the board of directors in implementation of the peer review process consistent with the Medical Staff Bylaws.

7. To review and establish criteria to ensure appropriate accreditation of each facility by The Joint Commission (TJC) and other accrediting bodies.

8. To perform such other functions as may be delegated to such committee by the board of directors from time to time.

9. The chairman of the Quality Subcommittee of each clinical department is charged with the responsibility to carry out an initial review of a single chart if a matter of concern has been brought to his attention by the Quality Improvement (QI) staff. Only this chairman or his designee can access the chart of a patient not his own for the purpose of an "issue of quality".

Another physician can be appointed by the subcommittee chairman to perform and initial review if the chairman feels that the case material is outside his area of professional expertise.

QI may be made aware of a request for a chart review through: (1) the Medical Staff Office (e.g. through the submission of a Patient Care Problem (PCP) form to that office); (2) Risk Management (through the submission of an Incident Report); or (3) the Chief of Staff. The notification to QI shall also include the patient's name and medical record number. The chairman of the appropriate departmental Quality Subcommittee shall be advised by QI as expeditiously as possible.

The result of such review will be reported to the Quality Subcommittee at its next regular or called meeting. That body shall: (1) notify the physician of its action and decide; (2) whether or not to submit a report to the chairman of the

Professional Review Committee.

Nothing in this policy shall preclude a physician from requesting another physician to review the chart of one of his patients if such request is made in writing. In this circumstance, the physician to whom the letter is addressed is to present the letter of authorization to the HIM staff before being given access to a specific chart.

B. Process Improvement Council (P.I.C.): The P.I.C. is responsible for quality oversight at the Regional Medical Center. This council consists of the Medical Director of Clinical Quality Improvement, and individuals who represent hospital leadership. Chief of Staff and chiefs-elect are Ad-Hoc members. Quality data, customer satisfaction data, and results of process improvement team activities are submitted to the PIC for evaluation. Coordination of quality-related multidisciplinary activities is a primary responsibility of the Process Improvement Council.

C. PEER REVIEW

In concurrence with the mission of Fort Loudoun Medical Center to produce programs and services of highest quality, the Medical Staff is organized to assess the quality of its programs as well as to evaluate those individuals who have been granted privileges to perform patient care.

The Medical Staff has a leadership role in organizational performance improvement activities. These activities are designed to ensure that when the findings of the assessment process are relevant to an individual's performance; the medical staff is responsible for determining their use in peer review or the ongoing evaluations of licensed individual practitioner's competence. The peer review process is responsible for in-depth assessments of an individual licensed practitioner's practice patterns and outcomes. Physician departures from clinical policy should not be interpreted as a breach of good medical practice. Such departures should be weighed individually. During the review process, the physician providing the care should be given the opportunity to clarify the documented details of the clinical care rendered. The goal of peer review should be improvement of patient care through physician education and process improvement. The results of peer review activities are considered in practitioner-specific credentialing and privileging decisions.

The conclusions reached through the peer review process are supported by a rationale that specifically addresses the issues for which peer review was

conducted, including as appropriate, references to literature and relevant clinical practice guidelines. In addition to the view of the reviewer, all members of the review committee shall be given the opportunity to express their opinion before conclusions are reached.

Procedure

A. Identification of records for review occurs through:
   1. outcomes, resources, blood usage, procedure monitoring, sentinel events, etc.;
   2. occurrence screens as approved by the Medical Staff;
   3. and case referral from other staff and/or committees.

B. Quality Support Services personnel complete section I of the Confidential Peer Review Worksheet when an occurrence is identified. Quality Support Services will then request a physician review of the case. Physician reviewers are assigned in the following manner:
   1. The Service line medical director will review applicable records (ex. if a surgical case is being reviewed, the medical director of Surgery will review the record)
   2. If the record being reviewed is the case of the applicable Service line medical director, the Chief of Staff will assign the physician reviewer
   3. The need for a reviewer outside the facility will be determined by the Chief of Staff or the Quality Committee

C. The reviewer has the option of calling the physician being reviewed to obtain additional information. The reviewing physician should complete the review and return the Peer Review worksheet to Quality Support Services within 7 days of review request. An exception to this timeframe will be made if the case requires review from a specialist not available at the facility. In the event that the case must be sent out of the facility for review, the timeframe for return of the review is increased to 30 days. Failure to comply with this timeframe will result in notification of the Chief of Staff by Quality Support Services.

D. The reviewing physician summarizes the case finding and recommendations in writing. This summary becomes part of the Quality Committee minutes.

E. If care issues are identified the case will be referred to the Quality Committee for further review.

F. After review by the Quality Committee, the Quality Support Services Manager will then notify the reviewed physician by certified letter written by the Quality Committee chairperson containing case findings, recommendations. This letter will state the patient name, findings, and the date, time and location of the next Quality Committee meeting. This letter will state that the reviewed physician has the right to respond in writing or in person to this case within the time period set by the Quality committee. This time period not to exceed 30 days. Although copies will not be made, the reviewed physician has the right to view the peer review worksheet prior to the Quality Committee meeting. This letter becomes part of the Quality Committee minutes.

G. During the case discussion at the next scheduled Quality Committee meeting only members of the medical staff, administration, and the Quality Support Services will be present. All other members of the Quality Committee will be asked to leave. After the case discussion, the reviewed physician is asked to leave the room. The assigned Disposition from the Peer Review worksheet is reviewed and a secret ballot is taken to either 1) change the disposition or 2) uphold the assigned disposition.

**** Only medical staff committee members may vote.

H. The reviewed physician will then be notified by certified letter of the committee's decision.

1. If the Quality committee members decide that no further action is necessary, no entry will be made in the physician's Quality file.
2. If the Quality committee takes action to send letters to involved medical staff for informational or educational purposes only, the letters are not placed in individual files but are retained with the Quality committee minutes.

I. If action is recommended, the Quality Committee decision will be forwarded to the next Medical Executive Committee (MEC) meeting.

J. The reviewed physician now has the option of appealing the Quality Committee's decision at the MEC level. If this is desired, the reviewed physician must notify Quality Support Services and/or the MEC Chairman within 2 days of receipt of the letter in #9 to ensure that the presentation by the reviewed physician will be placed on the agenda.

K. After case discussion at MEC, the appealing physician is asked to leave the room and a secret ballot is taken.
**** Only medical staff committee members may vote.

L. The appealing physician is then notified by certified letter written by the MEC Chairman of the final decision and is informed of the opportunity to file a letter in response to the report placed in the physician profile.

M. Only after the MEC's final decision will the peer review process be complete. The peer review documentation will then be placed in the physician profile. Any information to be retained in the physician profile must be approved by the MEC.

N. Timeframes: From the notification/discovery of fallout, completion of Section I of the Peer Review worksheet and the assignment of the reviewing physician must occur within 7 days. Completion of Section II of the Peer Review worksheet must be completed and returned to Quality Support Services within 7 days. The completion of the process from notification/discovery of fallout to the presentation to the Quality Committee, if applicable, must occur within 45 days. Failure to comply with these timeframes will result in notification to the Chief of Staff.

3. Physician/Staff/Family Complaints and Bylaw Violations

1. Identification of complaints occurs through letters or other written documentation by other physicians, staff, family, and patients.
2. Upon the receipt of a complaint, the involved physician will be notified by certified letter within 3 working days. The Chairperson of the Quality Committee and/or the Chief of Staff will also be notified by telephone or in person within 3 working days. An exception to this timeframe is made if the physician is unavailable.
3. The complaint/violation will proceed through the same review as outlined in steps I. 2. through I. 14.

FORT LOUDOUN MEDICAL CENTER MEDICAL STAFF MANDATORY PEER REVIEW OCCURRENCES:

1. Re-admission within 24 hours of discharge
2. Deaths where risk of mortality and severity of illness scores do not coincide
3. Death or hemorrhage following administration of thrombolytics
4. Serious injury, life threatening, or harm that requires the patient undergo significant additional diagnostic or treatment measures
5. Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in death, brain death, loss of limb or organ, impairment of limb, loss of bodily function

6. Delay in contacting provider leading to injury, increased morbidity, or death of a patient
7. A physician drug error leading to patient harm
8. Deaths of patients with working diagnosis and/or symptoms of arrhythmias, such as syncopal episodes, unexplained LOC, etc, who are not on telemetry at the time of death
9. Patients with no documentation by attending physicians during 24 hours prior to death
10. Elopement from the facility of a cognitively impaired patient without staff awareness resulting in death or serious injury.
11. Any other occurrence deemed pertinent by a Medical Director

ANESTHESIA PEER REVIEW ITEMS:

1. Incidents of additional reversal agents or re-intubation after arrival to the PACU
2. Incidents of reported intra-operative awareness
3. Neurological or cognitive deficit within 24 hours of anesthesia administration
4. Difficult intubation during induction leading to the placement of a tracheostomy tube
5. Cardiac or respiratory arrest during moderate sedation
6. Any other occurrence deemed pertinent by a Medical Director

SURGERY/INVASIVE PROCEDURE

1. Intra-operative deaths and deaths within 48 hours of surgery/anesthesia
2. Any wrong site, wrong surgery or wrong patient incidents
3. Surgery acquired burns 2nd or 3rd degree
4. Intra-operative or post procedure hemorrhage resulting in serious physical compromise, injury or death
5. Cancellation of a procedure after anesthesia induction
6. Major organ injury requiring increased procedure time and hospitalization
7. Discrepancy between pathology report and physician diagnosis
8. Surgery performed without appropriate privileges
9. Any other occurrence deemed pertinent by a Medical Director

All peer review outcomes are forwarded to the Department and Medical Executive Committee. The peer review conclusions are tracked over time, and the actions based on peer review are monitored for effectiveness.

Performance Improvement

Fort Loudoun Medical Center has defined quality as one of its values. Therefore, Fort Loudoun Medical Center will utilize principals and tools of quality improvement in

daily operations and in planning for new processes and change. Its governing board, medical staff, leadership and staff from all departments and disciplines will work together to improve patient-focused and organizational focused processes and outcomes. The Medical Executive Committee as a committee of the Medical Staff is accountable to the Board of Directors for the overall quality of medical care rendered to patients in the hospital assuring that appropriate ongoing, systematic, objective performance measures of patient care and/or performance improvement are in place. This is accomplished by receiving and acting on the recommendations of the Medical Staff Departments/Quality Subcommittees or the Performance Improvement Council and by reporting of these activities to the Board of Directors.

Each Medical Staff Department is responsible for involving members of the Department in performance improvement activities including the establishment of performance measures used to monitor and evaluate the quality of care provided by the department. Additional responsibilities include:

1. Identification of the important aspects of care in each clinical department and development of criteria and indicators for the purpose of measuring and assessing performance and outcome, including the review of appropriateness of diagnosis and treatment.
2. Analyze data collected for each indicator, reach conclusions, make recommendations and initiate actions to improve performance. When findings relate to the performance of a licensed independent practitioner, the medical staff determines their use in peer review, ongoing monitoring, and the periodic evaluation of the individual's competence.
3. Communicate findings, conclusions, recommendations, and actions taken to the department members and the Medical Executive Committee.
4. Annually assess the effectiveness of actions and document the improvement in patient care.
5. Make recommendations to the Credentials Committee for clinical privileges based on the findings related to performance of individuals with hospital privileges.
6. Participate in Performance Improvement Teams as needed, taking a leadership role in the assessment and improvement of both clinical and non-clinical processes.
7. Participate in the review of the following processes or outcomes:
   a) Medical assessment and treatment of patients.
   b) Operative and other procedures that place the patient at risk. Processes measure include:
      (1) Selection of the appropriate procedure.
      (2) Patient preparation for the procedure.
      (3) Performance of the procedure and patient monitoring.
      (4) Post procedure care.
      (5) Post procedure patient education.

(6) Outcomes.

c) Use of Blood and Blood Components. Processes measure include:
(1) Ordering practices.
(2) Distribution, handling, and dispensing of blood and blood components.
(3) Administration of blood and blood components.
(4) Monitoring the effects of blood and blood components on patients.

d) Medication Use. Processes measured:
(1) Prescribing and ordering.
(2) Preparing and dispensing.
(3) Administering.
(4) Monitoring the effects on patients.

e) Quality of the Medical Record including timeliness, completeness and legibility of the record.

f) Utilization and Resource Consumption including appropriateness of admissions and continued hospital stays.

g) Surveillance, prevention, and control of infections as reported to the Infection Control Committee.

h) Risk Management activities as reported to the Safety Committee.

i) Management of the patient care environment as reported to the Safety Committee. The 7 plans include:
(1) Safety
(2) Security
(3) Hazardous material and waste management
(4) Emergency preparedness
(5) Life safety
(6) Medical equipment
(7) Utility systems

j) Mortality review, including autopsy results.

k) Pharmacy activities as reported to the Pharmacy and Therapeutics Committee

l) Clinical practice patterns including the review of internal and external clinical outcomes data and significant departures from established patterns.

m) Patient perception of care and services as related to meeting patient needs and expectations.

n) Participation in the measurement, assessment and improvement of other patient care processes. The processes include, though are not limited to, those related to:
(1) Education of patients and families.
(2) Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient.

CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines (also known as practice parameters, practice guidelines, patient care protocols, standards of practice, clinical pathways, and care maps) are evidence-based and have shown to be efficacious within defined patient populations or services. They provide a means to improve quality, assure appropriate utilization of healthcare services, and enhance the value of healthcare services. Clinical Practice Guidelines assist practitioners and patients in making clinical decisions on the prevention, diagnosis, treatment and management of selected conditions. They also serve as an effective way to design or improve process (es) by reducing variance.

A. Selection Criteria

When evaluating the use of Clinical Practice Guidelines the organization will consider the following:

- Sources such as the Agency for Healthcare Research and Quality (www.ahrq.gov/), the AMA's Directory of Practice Parameters, Professional Medical Societies and Physician organizations, professional healthcare associations, and local organizations.
- Modification(s) necessary to support guideline implementation.
- Whether the guideline(s) can assist the practitioner in making decisions about appropriate health care for specific clinical circumstances.
- Whether the guideline(s) are based on current professional knowledge and are reviewed and revised periodically.
- Mechanisms for anticipating and evaluating variation in guideline(s) compliance.
- Resources necessary for the implementation and evaluation of the guideline(s).

B. Implementation Criteria

- The focus diagnoses, procedures, and/or conditions must be identified by organizational leaders, based on accurate, in-depth analysis of available data:

  - Patient population effected.

  - High volume, high cost, high risk, or problem prone data,

  - High variability in processes that require a new design to bring the clinical system under control.

- The Clinical Guideline/Pathway will be developed by a interdisciplinary team consisting of representatives that provide direct care to the identified patient group;
- The Clinical Guideline/Pathway should consider the entire episode of

illness, outlining care requirements for each discipline and each level of care, across the continuum.

- The Clinical Guideline/Pathway will be reviewed and approved by the Medical Staff.
- After implementation, the effectiveness of the Clinical Guideline/Pathway will be evaluated, and modified as necessary.

C. Physician Profiles Policy: Physician profiles are maintained on all physicians who practice at Fort Loudoun Medical Center. These files contain results of Quality Improvement activities. Purpose: Physician profiles provide information on the physician's clinical and/or technical skills. 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 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, the Chief of the Department (to members of his/her department), the individual physician (to his own), the Director of Clinical Effectiveness and Infection Control, and Outcome Coordinators.

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, focused reviews), surgical and invasive procedure review, medical record review, blood usage review, infection control review, PCP's (Patient Care Problems), patterns or trends from complications screening, and unanticipated events.

a) An unanticipated event for purposes of referral to the Quality Subcommittees for their review is defined as follows: An unanticipated event has occurred when the patient’s hospital course does not follow its expected path; and as a result the patient expires or requires additional treatments or surgery that were not part of the original plan of care AND the

event is not a usual or recognized complication for a given disease process or medical intervention.

No patient-specific event will be entered into a physician's quality file until such has been presented to the appropriate Medical Staff Quality Subcommittee, and a decision to enter such patient-specific information has been made by the physicians comprising said committee. Physicians will be notified of the placement of information from the review of unanticipated events in their files.

b) Data are reported (when available) as follows:

Blood Utilization: crossmatch to transfusion ratio

Infection Rate for surgeons: attestation by Hospital Epidemiologist

Pre-op/post-op/pathology discrepancies: serious discrepancies will be reviewed and approved for inclusion by the appropriate Quality Subcommittee 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.

Complications monitoring: rates or values derived from the complications screening will be reviewed by the appropriate Quality Subcommittee before being placed in the physician's file. Expression of the data is dependent upon the data type.

Unanticipated events: number of events reviewed by the appropriate Quality Subcommittee

C-section rates:

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%

Patient Care Problems (PCPs): those PCPs reviewed by the Credentials Committee

Medical Records suspensions: number of times the physician has been suspended from the active medical staff in the preceeding calendar year

Medical Records Clinical Pertinence: for each data element, the % deficient is calculated as the number deficient/number of charts screened for that element.

5. Volume data are also included in the physician's profiles: numbers of admissions, number of consults, and number of surgical cases for which the physician is privileged.

6. If additional information is requested to be retained in the physician profile, the requestor must receive the approval of the Medical Executive Committee prior to placing this information in the physician profile.

Each department recommends renewal or revision of clinical privileges based on a summary of information in the physician profile.

It is the intent of the Peer Review process to effectively monitor and improve patient care through a fair and objective mechanism.

IV. GENERAL PRINCIPLES OF MEDICAL CARE

A. All drugs and medications administered to patients shall be those listed in the latest edition of the "United States Pharmacopeia", "National Formulary", or "New Nonofficial Drugs" or those approved for marketing by the Food and Drug Administration. Drugs for investigational use will be handled in accordance with principles developed by the American Hospital Association and the American Society of Hospital Pharmacists. Reports concerning any investigational drug will be submitted as required by the Food and Drug Administration. Investigational drugs need to be approved by the IRB.

B. All orders for medications and treatments shall be recorded by the responsible physician, dentist or consultant, and signed. Verbal orders shall be dealt with as in:

II. Medical Records
B. Content of the Medical Record
14. Diagnostic and therapeutic orders -

C. At the time of operation all previous orders are cancelled.

D. Psychiatric and/or mental health consultations and treatment will be requested for all patients who have attempted suicide or have taken a chemical non-alcoholic overdose unless the patient refuses in writing or unless mitigating circumstances are outlined in writing in the chart. Mental health consultations in such situations may be performed by Psychologists, Master's of Social Work, and Psychological Examiners licensed by the Board of Healing Arts of the State of Tennessee and credentialed through the Medical Staff. They may be permitted to exercise privileges only under the direct supervision of physician Staff members. - Reference: Suicide Precautions ECSF.015 - Members in good standing of the Medical Staff.

V. SURGERY

THE FOLLOWING APPLY TO THE GENERAL OPERATION OF THE SURGICAL SUITE.

i. Surgical privileges are delineated for all physicians doing surgery in accordance with the competencies of each physician. A roster of physicians specifying the surgical privileges of each is kept in the confidential files of the operating room supervisor and in the files of hospital administrator.

ii. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist/podiatrist and physician member of the medical staff.

a. Dentist/podiatrist responsibilities:
   (i.) A detailed history justifying hospital admission
   (ii.) A detailed description of the examination and a pre-operative diagnosis
   (iii.) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.
   (iv.) Progress notes as are pertinent to the patient’s condition.
   (v.) Post-operative summary statement.

b. Physician's responsibilities:
   (i.) Medical History pertinent to determine the patient's general health.
   (ii.) A physical examination to determine the patient's condition prior to anesthesia and surgery.
   (iii.) Supervision of the patient's general health status while hospitalized.

c. A physician member of the medical staff shall be notified and available during these surgical procedures.

iii. The operating surgeon and anesthetist/anesthesiologist 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 as he/she enters the operating room and notify the surgeon.

iv. 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 do so.

v. 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 services are provided.

vi. Persons entering an operating room are to be kept to a minimum and restricted to those persons whose presence is expressly approved by the operating surgeon and the acting operating room supervisor.

vii. In the event the operating surgeon is unable to continue with an operative procedure and no physician first assistant is present, the Hospitalist or physician on duty in the emergency department will be requested to attend the patient and, if necessary, stabilize the patient until relieved by another physician.

Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. The limited categories of specimens that may be exempted include the following: specimens that by their nature or condition do not permit fruitful examination such as cataract, orthopedic appliance, foreign body, intrauterine device, toenails, teeth, or grossly normal placentas, fingernails, bunions, uncomplicated cutaenous scars, foreskin. The pathologist's report shall be made part of the patient's medical record.

VI. EMERGENCY DEPARTMENT AND EMERGENCY SERVICES

1. The Emergency Department shall be staffed by qualified physicians approved by the Medical Staff and by the Board.

2. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department. This shall be in accordance with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Medical Staff shall have overall responsibility for emergency medical care.

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

4. Physicians will ensure that rosters of emergency call coverage are provided to the Emergency Department. An Emergency Department physician shall be appointed by the Chief of Staff as Director of Emergency Services. He shall be an ACLS certified physician who is knowledgeable in the procedures and techniques of all Emergency Department services. He shall be responsible for the quality of emergency department and accountable to the medical staff and to the hospital administration for the activities of the emergency department.

5. The duties and responsibilities of all personnel serving patients within the emergency department shall be defined in a procedure manual relating specifically to this facility. When approved by the medical staff and governing body, it shall be appended to this document.

6. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital records if such exists. The record shall include:

   a. Adequate patient information
   b. Information concerning the time of the patient's arrival, means of 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.
   h. Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.

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

8. There shall be a periodic review of emergency department medical records by the appropriate committee of the medical staff to evaluate the quality of emergency medical care along with a report to the Medical Staff.

9. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes at least one (1) member of the medical staff, the Chief Nursing Officer, and a representative from hospital administration. When approved by the medical staff and governing body, the plan shall be appended to this document

10. Physicians will participate in the hospital's disaster plan. It is their responsibility when so notified to report to their assigned stations.

11. Physicians will participate in the hospital's safety plan.

VII. RADIOLOGY

1. The Medical Director of Radiology shall be a member of the medical staff and shall be certified or Board eligible by the American Board of Radiology.

2. Radiologists will be responsible for making reports on the outcome of all imaging studies. Reports are to be on the chart within twenty-four (24) hours. The Radiologists are responsible for inservice education which must be documented for all hospital radiological personnel at least twice yearly.

3. Radiologists will be responsible for coverage twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year.

VIII. LABORATORY

1. The Medical Director of Laboratory Services shall be a member of the medical staff and shall be certified or Board eligible by the American Board of Clinical and Anatomical Pathology.

2. He acts as a liaison between laboratory and hospital staff, assures quality lab procedures, assures prompt return of reports, and participates in a continuing education program for technicians at least twice yearly.

IX. ANESTHESIA

1. The attending surgeon will be responsible for evaluating the patient as to the patient's need for surgery and anesthesia. Once this evaluation is made and recorded in the medical record, the anesthetist will evaluate the patient and choose the appropriate anesthesia plan of care in accordance with the AANA guidelines published by that organization. Except in extreme emergency cases, this evaluation should be recorded prior to the patient's transfer to the anesthesia or operating area and before preoperative

medication has been administered. While the choice of a specific anesthetic agent or technique may be left up the individual administering the anesthesia, the pre-anesthesia medical record entry should at least refer to the use of general, spinal or regional anesthesia. For physician/podiatrists anesthesia plan signature requirements, please see E. General Rules Regarding Hospital Services, 1. Surgical Services, d. Medical Record Requirements, item iv. on page 8.

2. All nurse anesthetists shall be graduates of an approved nursing school and School of Anesthesia. They shall be granted privileges by application to the Credentials Committee, the medical staff, and the governing board. This application shall be updated as duties change, or every two (2) years at the time of medical staff reappraisal and reappointment. CRNAs shall be able to provide anesthesia under the overall direction of a physician who shall authorize the administration of all legend drugs including anesthetic agents. They shall have the competence to induce anesthesia, maintain anesthesia at the required levels, manager untoward reactions, and control of his vital functions. Privileges granted CRNAs shall consist of administration of the following types of anesthesia: general; spinal; Bier block; regional block; epidural; topical; and IV sedation.

3. 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 a surgical specialty or 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.

X. SUSPENSION OF ADMITTING PRIVILEGES

Reference: Medical Records and Bylaws

XI. DELINEATION OF PRIVILEGES

The delineation of privileges forms to apply for clinical privileges are filed in Medical Staff Services and updated at reappointment by the Medical Staff Departments.

XII. COMMITTEES

A. Present standing committees are: Credentials/Bylaws and Medical Executive Committees.

B. Staff Committees, to include but not limited to Nominating, Surgery, Pharmacy and Therapeutics, Quality, Acute Care, HIM, and Utilization Review shall be appointed by the Chief of Staff and all committees shall be reappointed annually, provided that the persons appointed to a committee shall continue to serve until their successors are appointed. Unless otherwise specifically provided herein, the Chief of Staff shall appoint the Chairman of all Staff Committees.

XIII. MEDICAL STAFF WELLNESS COMMITTEE

Policy

The term "impaired professional" is used to describe the practitioner who is prevented by reasons of illness or other health problems from performing professional duties at the expected level of skill and competency. In some contexts, impairment also implies a decreased ability and/or willingness on the part of the affected individual to acknowledge the problem or to seek help to recover. Clearly, such a situation places the professional at risk, and may pose an actual or potential risk to public health and safety.

Fort Sanders Medical Center, in participation with its medical staff has instituted an Impaired Professional Program. The purpose of the program is to educate hospital leaders, medical, allied health and clinical staff about licensed independent practitioner health, address prevention of physical, psychiatric, or emotional illness, and to facilitate confidential diagnosis, treatment and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition. The goal of this program is assistance and rehabilitation, rather than discipline, and to aid licensed independent practitioners in retaining or regaining optimal professional functioning, consistent with protection of patients. Fort Loudoun Medical Center has formed a Professional Wellness Committee to coordinate the assistance provided to impaired professionals. The Professional Wellness Committee is composed of six (6) members of the active medical staff, holding a six (6) year term, with two (2) members rotating off the committee, then adding two (2) more every two (2) years. Any ex-officio member may be asked to participate as needed. The committee will report to the Medical Executive Committee. These physicians are experienced and interested in dealing with issues of professional impairment.

The Professional Wellness Committee shall periodically review educational resources and opportunities available to hospital administration, staff, and employees regarding impaired or disabled LIPs, and/or devise its own educational resources, for the purpose of promoting the use of such resources by hospital administration, staff and employees with the goal enabling all hospital professionals to recognize potential LIP impairment issues or problems, and to appropriately report or refer identifiable impairment problems pursuant to this policy.

The committee members will be responsible to provide education regarding healthcare professional impairments. Education will:

A. Be provided on an annual basis during one of the regularly scheduled General Staff meetings
B. Be provided in written format at time of initial appointment and reappointment to the medical staff
C. Include issues related to licensed independent practitioner health, prevention of physical, psychiatric and/or emotional illness and the general components of the Impaired Professional Program

Elements of the program

1. Education of organizational leaders and the medical staff about illness and impairment recognition issues specific to licensed independent practitioners:
   A. The hospital will sponsor an annual educational program regarding illness and impairment issues.
   B. Licensed independent practitioners will be issued written information regarding illness and impairment issues at time of initial appointment and reappointment to the medical staff
   C. The education will include:
      1. At-risk criteria
      2. Signs and symptoms in identification of the impaired healthcare provider
      3. Management of the affected healthcare provider

2. Referral to the Professional Wellness Committee:
   A. Licensed independent practitioners will be allowed to self-refer to the program
   B. Referrals of licensed independent practitioners will be allowed by any member of the organization
      1 Referrals can be made on a confidential basis

3. The affected licensed independent practitioner will be referred to the appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition or concern

4. The confidentiality of the individual referred to the Professional Wellness Committee or the LIP seeking referral, will be strictly maintained with the following exceptions:
   A. State and federal regulatory limitations (if applicable)
   B. Ethical obligations
   C. When maintaining confidentiality threatens the health and/or safety of a patient or patients

   In all instances, every effort to protect the confidentiality of the individual referred for assistance will be made.

5. All complaints, allegations or concerns regarding the potential impairment of a licensed independent practitioner will be thoroughly investigated and evaluated for validity.

6. The affected licensed independent practitioner will be monitored until the rehabilitation or any disciplinary process is complete, to assure the safety of the patient population under his/her care.
   A Method of monitoring will be determined by the Professional Wellness Committee and the Physician Advisor of any external resource which may be utilized.
   B Monitoring will continue until the Professional Program Physician Advisor is able to verify that the impairment for which the licensed independent practitioner was referred to the program:
      1. No longer exists

2. No longer impacts the quality of patient care provided by the licensed independent practitioner

C. Periodic monitoring may be conducted on a specific practitioner if deemed necessary by the Professional Wellness Committee and the Physician Advisor

7. Reporting to the medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment

A. Any individual within the organization has the responsibility to report concerns regarding unsafe treatment by licensed independent practitioners
B. Reports should be made directly to the licensed independent practitioner's service chief or department chairperson
C. Reports may also be made to the Chief of Staff
D. Reports of this nature are to be kept confidential and will follow the routine medical staff evaluation process
E. The informant has the right to request and receive confidentiality regarding the referral

Procedure

It is the policy of Fort Loudoun Medical Center that referrals of impaired LIPs be made to the Professional Wellness Committee, who in conjunction with appropriate professional internal or external resource(s) will arrange for assessment, treatment, support and monitoring to facilitate recovery and appropriate return to work.

All professional employees and medical staff members are strongly encouraged to express concern about an impaired LIP and to make a referral by contacting the Professional Wellness Committee in the hospital. Medical staff members who are concerned about their own status are encouraged to self-report to the Professional Wellness Committee. Any member of the Committee receiving a report or referral shall report the concern to the Committee as a whole, which shall then make an evaluation whether the concern is a credible one warranting further review. If the concern is found not to be credible, no further reporting or proceedings shall occur. If the concern is determined to be credible, the concern will be handled in the following manner:

1. The committee will ask the referral source to have others who may have relevant information contact a member of the committee. The committee does not conduct formal investigations, but rather serves as the recipient of information from concerned colleagues and other sources. The committee will consider each case by reviewing the documentation available and conducting interviews where appropriate.

2. It is the policy of the Professional Wellness Committee not to disclose the source of referrals to the physician in question. Except for reports required or consultations permitted under this policy, all proceedings of the Professional Wellness Committee shall be confidential, and subject to the privileges of the Tennessee Peer Review Law.

3. The Professional Wellness Committee will collect whatever information is readily available concerning the problems and will contact the appropriate resource(s) to discuss ways in which to proceed.

4. The Professional Wellness Committee, where appropriate, will do the following:

a) Encourage the LIP to seek assessment and/or treatment services.

b) Contact the Medical Executive Committee and/or the Chief of Staff if the impaired practitioner has entered into a recovery agreement. Notification is also given if the committee has failed to successfully engage the LIP in an appropriate assessment/treatment/recovery program and the committee believes that impairment exists.

c) Confirm the LIP's cooperation with treatment and recovery activities.

d) Make efforts to assist the LIP to continue in his or her professional duties to the extent that the practitioner is considered able to do so.

e) Write an agreement for monitored recovery that refers to the treatment/recovery program. This agreement requires continued compliance with the program.

f) In cases where the LIP has discontinued or limited work, aid him or her to return to work as soon as possible with the approval and cooperation of both the committee and the appropriate resource.

The Professional Wellness Committee will be responsible for monitoring the effectiveness of the impaired LIP's treatment plan in conjunction with the appropriate resource. When the Professional Wellness Committee considers the LIP to be able to re-enter the practice and knows the LIP is enrolled and actively participating in the monitored recovery plan, the CAO, Chief of Staff and the Medical Executive Committee will be so notified.

If the LIP is unable to demonstrate involvement in a recovery process, or violates the agreement with the appropriate resource or with the hospital, the committee will so notify the Medical Executive Committee for formal action in accordance with the medical staff bylaws. Having done so, the committee will remain available to assist in a recovery plan if the LIP agrees to participate. Any further action against the LIP will be the responsibility of the Medical Executive Committee in accordance with the bylaws.

All licensed independent practitioners are eligible for participation in the Impaired Professional Program.

XIV. UTILIZATION PEER REVIEW POLICY AND PROCEDURE

The Medical Staff has a leadership role in organizational performance improvement activities. These activities are designed to ensure that when the findings of the assessment process are relevant to an individual's performance; the Medical staff is responsible for determining their use in peer review and the ongoing evaluation of the licensed individual's competence.

Purpose: The Utilization Review Committee will function as a Medical Staff committee for Fort Loudoun Medical Center and is a "medical review committee" within the meaning of Tennessee Code Annotated § 63-6-219 because it functions as a utilization review committee as described by that statute. In compliance with the Medicare Condition of Participation requirements, the UR Committee exists to assist in physician advisor interventions relative to utilization and resource consumption, discharge delays, and analyze approved data and trends to provide comparative data in assisting the evaluation of the licensed independent practitioner's practice patterns.

Policy: The Clinical Effectiveness Department of Fort Loudoun Medical Center will provide a systematic approach to the evaluation and delivery of patient care through the Case Management and Quality (Clinical Effectiveness) program. Individual cases meeting the criteria for additional review will be forwarded to the Utilization Review Committee and through the appropriate Medical Staff Departmental Quality Subcommittee, in accordance to the Medical Staff Rules and Regulations.

Criteria for Peer Review (includes but is not limited to):

- Failure to meet admission or level of severity criteria established by payors[1]
- Failure to meet continued stay criteria established by payors
- Delays in the provision of services
- Resource and utilization consumption

Procedure:

1. The Case Manager identifies a case not meeting criteria and documents actions taken on in the medical record with an initial confidential Query sheet or the Clinical Effectiveness Communication Worksheet (from Utilization Management) for physician feedback. Case referred to the Director of Clinical Effectiveness. Cases are either trended or referred for peer review through the U.R. Committee process. All cases are entered into the HBOC UM database.
2. Cases identified for peer review are presented to the appropriate Medical Staff Quality Improvement Subcommittee for discussion as designated by the U.R. Committee.
3. Committee recommendations and actions will be documented on the Utilization and Resource Management Peer Review Form and will be maintained in the individual physician's Quality Profile.

[1] Milliman & Robertson and InterQual Criteria (as defined in The Utilization Management Plan PI.CM.004]).

4. All Peer review outcomes are forwarded to the Department Chair of the relevant service line/department and then to Medical Executive Committee if appropriate.
5. Peer review findings are tracked over time, and actions based on physician peer review findings are monitored for effectiveness.

Information concerning individual licensed independent practitioner's efficiency of clinical practice patterns is privileged and confidential. Peer review is protected by the Healthcare Quality Improvement Act (HCQIA-Title IV of Pub.L. 99-660) and Tennessee Code 63-6-219.

XV. SELF-PRESCRIBING AND TREATMENT OF IMMEDIATE 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 is prohibited.

Immediate Family Members:

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 drug.

XVI. INAPPROPRIATE BEHAVIOR POLICY

FORT LOUDOUN POLICY ON INAPPROPRIATE BEHAVIOR

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 the 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 as well as the CAO and Chief of the Medical Staff.

DEFINITION OF "INAPPROPRIATE BEHAVIOR"

"Inappropriate offensive 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 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 policy dealing with physician behavior (hereafter called: Behavior Policy") is to be used only for behavioral issues. The existing Professional Review Committee is to be used as the forum for behavioral related issues. Reports kinds may be submitted by (1) the chair of the Professional Review Committee, (2) the department chair, (3) the chief of staff, or (4) the chief administrative officer. That committee will determine whether an issue is significant enough to warrant further evaluation and formal investigation.

Any physician or employee may report concerns regarding inappropriate physician behavior. 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). Confirmed reports of such grievances should be addressed as presented above. In addition to the informal sharing of concern regarding "inappropriate physician behavior", a formal report may also be filed following this policy using the "Unified Behavior Reporting Form".

Nothing herein shall prohibit collegial or informal attempts to address "inappropriate behavior". The individual receiving the grievance (Manager or member of the Medical Staff) should facilitate discussion with the physician involved to resolve the issue. 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.

If the Professional Review Committee determines that a credible complaint warranting evaluation has been filed the physician so reported will be notified. After evaluation, a meeting will be held with the physician, the chairman of the Professional Review Committee (chief-elect of the medical staff) and the chairman of the appropriate clinical department. The discussion between the department chief, the chairman of the Professional Review Committee and the physician is to be collegial and limited to the facts as reported. The physician will be informed that any inappropriate conduct must cease. A report of this meeting will be filed in the physician's Quality file. The physician will have the opportunity to file a written rebuttal, which will also be placed in his 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. Information placed in a physician's Quality file remain until the time of his/her next reappointment at which time they time they are destroyed unless, at the discretion of the then chairman of his/her

department, such information is felt worthy of trending or otherwise preserving. All such files are protected under the provisions of peer review and are regarded as confidential.

If another grievance is reported, 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 Professional Review Committee via the Medical Staff Office. In either event, the report is to be forwarded to the Professional Review Committee. The chief of staff is then to be notified. The Professional Review Committee will discuss this new complaint and if warranted, the chairman of that committee and the chief of the appropriate clinical department will again meet with the physician. This meeting constitutes a more serious step than the previous meeting. 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 to not 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 again 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.

At its discretion the Professional Review Committee may decide that a reported behavior is sufficiently egregious to warrant reporting same to the Credential Committee, even after only a single event. The Credentials Committee will then determine what action to take under the Medical Staff Bylaws. This same approach may also be elected after repeated episodes of disruptive behavior.

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 precautionary suspension, and removal from the premises, under the authority of the Bylaws.

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

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. The documentation should include:

1 Date and time of 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 Rick 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 related 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.

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