METHODIST MEDICAL CENTER OF OAK RIDGE

MEDICAL STAFF RULES AND REGULATIONS

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General Medical Policies

I. Inpatient Care

A. All inpatients shall be seen at least daily by a physician or an appropriately credentialed advanced practice professional. If the supervising physician chooses for the APP to perform daily rounds, the APP will function under the direct supervision of the collaborating physician/group. Evidence of communication between the supervising physician and APP is required in the medical record daily.

B. A proper history and physical examination shall be performed and dictated or written for all patients within 24 hours of admission by an appropriately credentialed individual. The attending physician will sign or co-sign all history and physicals.

C. A proper discharge summary shall be dictated or written on all hospital stays longer than 48 hours and should briefly cover all pertinent aspects of the hospitalization. This summary should include the following: All pertinent laboratory and x-ray findings, operations, consultations, admitting and final diagnoses, discharge instructions to the patient, and the patient's condition at discharge.

II. Physicians Orders, Receiving and Implementing

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

POLICY:

A. Only licensed nurses may accept verbal or telephone orders from the physician. Other persons who are credentialed in their field of service may accept and document orders <u>which they will implement</u>.
   For example: Registered and certified respiratory therapist may take telephone or verbal orders concerning respiratory treatment that they will administer.

B. Verbal communication of prescription medications should be limited to urgent situations where immediate or electronic communication is not feasible.

C. All orders on the Doctor's Order Sheet, whether written, verbal or telephone, must be signed by the attending physician within 48 hours. However, if the hospital's read-back and verify process is followed, the verbal orders shall be authenticated according to State Law effective 7/1/11, no later than fourteen (14) days after the date of the verbal order.

D. All signatures must be legible and contain at least the first initial, last name and title (M.D., R.N., L.P.N.)

E. Standing orders must contain sufficient and exacting information to facilitate their being used repetitiously. They must be dated and signed by the physician or covering physician.

F. Verbal or telephone orders must be given <u>directly</u> to appropriate hospital staff by one of the patient's physicians. This policy applies, also, in the event that the patient or patient's family member is a physician.

G. In certain circumstances, orders from a party other than the physician may be accepted and implemented. For example, approved physician agents (NP's or physician assistants) may write or give orders according to their respective protocols. RNs or LPNs in a physician office or in surgery may

transmit verbal orders when the physician is unavailable to speak directly with hospital staff. The person receiving the order will document it on the order sheet, indicating the nurse from whom the order was relayed.

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

H. Verbal or telephone orders must be entered on the physician's order sheet by the person receiving the order indicating:
   a. Date and time
   b. Physician's name
   c. Name and title of person receiving order
   d. Patient name
   e. Drug name
   f. Dosage form
   g. Exact strength or concentration
   h. Dose frequency and route
   i. Specific instructions
   j. Indication of either telephone order (T.O.) or verbal order (V.O.)

I. A radiologist's order for X-ray prep or repeat of a procedure may be accepted by a nurse via the X-ray technician.

ESSENTIAL STEPS IN PROCEDURE:	KEY POINTS
A. Transcription	
1. After writing orders, the physician will pull out red or green flag on chart divider. Orders are to be taken to unit secretary's desk.	Red Flag - Stat Orders Green Flag - Non-stat Orders
2. When unit secretary receives orders, she/he processes them using medication administration records. All ancillary department orders are entered through the computer. When all orders have been transcribed completely, the unit secretary signs her name and title, date, and time, and returns orders to team center desk. The computer order number is written next to each order on the physician's order sheet.	Unit secretary uses black ink to sign completed orders.
3. The Medication Administration Record /IV Administration Record are checked and co-signed on the Physician Order Sheet by the RN or LPN to ensure accuracy of transcription.	
4. When an order is unclear, or the nurse is unsure of the safety or clarity, she consults with the prescribing physician.	
5. Upon completion of checking orders for completeness and accuracy, the nurse will sign his/her name and title, date, time.	This is to be written in "RED."
B. Verbal Order	

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

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

3. Only approved abbreviations should be used.

III. Transfer of Patient Care

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

IV. Attending Physician's Responsibility for Signing Death Certificate

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

V. Multidisciplinary Progress Notes

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

VI. Emergency Services

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

Director of Emergency Services – Emergency 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 emergency medicine; 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.

VII. Self-Prescribing and Treatment of Immediate Family Members

A. Self-prescribing:

1. A physician cannot have a bona fide doctor/patient relationship with himself or herself.
2. Only in an emergency should a physician prescribe for himself or herself schedule IV drugs.
3. Prescribing, providing, or administering of schedule II and III drugs to himself or herself is prohibited.

B. Immediate Family Members:
   1. Surgical or non-surgical treatment of immediate family members should be reserved only for minor illnesses or emergencies.
   2. Appropriate consultation should be obtained for the management of major or extended periods of illness.
   3. No schedule II, III, or IV controlled substances should be dispensed or prescribed except in emergency situations.
   4. Records should be maintained of all written prescriptions or administration of any drug.

PHYSICIAN'S HEALTH

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

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

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

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

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

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

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

To the extent possible, issues of physician health will be identified and managed separately from the medical staff disciplinary rules and regulations. This will be accomplished through a stepwise process. The initial complaint will be handled collegially between the physician and his/her department chair and/or Chief Of Staff. If there is another occurrence or the physician chooses to ignore the collegial advice of his department chair or Chief of Staff, the department chair and the Chief of Staff will meet collegially with the physician in question.

If these friendly interventions do not suffice or the nature of the problem is of such gravity that it precludes non-disciplinary interventions, the Physicians Health Subcommittee will proceed in accordance with the bylaws regarding the specific incident.

IMPAIRED PHYSICIAN POLICY/INAPPROPRIATE BEHAVIOR POLICY
GENERAL POLICY OBJECTIVE

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

POLICY REQUIREMENTS

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

DEFINITION OF "IMPAIRED PHYSICIAN"

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

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

DEFINITION OF "INAPPROPRIATE BEHAVIOR"

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

1. Violence, meaning behavior intended to cause harm to either person or property or behavior bearing a substantial possibility of causing such harm, whether intended or not.

2. Threats of violence.

3. Carrying weapons.

4. Alcohol intoxication or use of any illegal drug or inappropriate use of controlled substances while on hospital property.

5. Inappropriate and disrespectful verbalization with respect to an individual or individuals.

6. Sexual or other harassment of an individual or individuals is inappropriate behavior. However, this behavior is handled as a separate issue. Refer to page 11.

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

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

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

(3) The third tier is used for either the third grievance or an episode felt to warrant bypassing of either the first two tiers, and involves the Physician Health Subcommittee of the Medical Executive Committee. A report will be placed in the physician's quality file, and the physician has the right to file a written rebuttal. Any decision to remove information placed in a physician's quality file must be approved by a simple majority of the Physician Health Subcommittee of the Medical Executive Committee. All such files are protected under the provisions of peer review and are regarded as confidential.

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

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

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

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

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

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

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

1. Date and time of the questionable activity.

2. The circumstances surrounding the situation.

3. A description of the occurrence limited to factual, objective language as much as possible.

4. The consequences, if any, of the activity as it relates to patient care or hospital operations.

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

6. Physician's response to grievance.

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

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

REHABILITATION

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

REINSTATEMENT

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

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

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

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

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

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

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

Confidentiality of physician records is protected under Tennessee Code Annotated 63-6-219, which states that the records, forms, and knowledge collected for and/or by individuals or committees assigned to professional review

functions in a health care facility are confidential and are not public records and as such are not subject to court subpoena.

POLICY ON SEXUAL HARASSMENT INVOLVING A PHYSICIAN

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

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

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

Procedure to Investigate a Complaint of Sexual Harassment Involving a Physician

1. Reports of sexual harassment from physician, nurse, other MMCOR employee, or patient who observes or who has been a victim of sexual harassment shall be made in writing and signed by the person preparing the complaint. The complaint shall include a factual description of the incident, including quotations of any offending language used.

2. Any MMCOR employee report of sexual harassment involving a member of the Medical Staff shall be submitted to the employee's supervisor, who shall forward it to the Chief Administrative Officer, or other member of the Senior Administrative Team. If an employee's report of sexual harassment involves his or her supervisor, or if the report concerns conduct that the employee believes has been or will be condoned by the supervisor, the employee may submit the report directly to the Chief Administrative Officer.

3. All patient reports of sexual harassment involving a member of the Medical Staff, as well as reports by one Medical Staff member filed against another Medical Staff member, shall be submitted directly to the Chief Administrative Officer, or other members of the Senior Administrative Team.

4. The Chief Administrative Officer shall immediately notify the Chief of Staff upon receipt of a report complaining of sexual harassment. These individuals, or such other individuals who shall be designated by the Chief Administrative Officer, shall interview the individual who filed the report and, when possible, others who were present when the incident occurred.

5. After interviewing the individual who filed the report and others who were present, or receiving a report of such interviews, the Chief Administrative Officer and the Chief of the Medical Staff shall determine whether the report of sexual harassment is credible. If a determination is made that the complaint is credible, the Chief Administrative Officer and the Chief of the Medical Staff shall determine to handle the matter either on a formal basis, by referring the matter for a formal review pursuant to the Medical Staff

Bylaws, or on an informal basis by scheduling a meeting with the individual who has allegedly engaged in the improper conduct.

6. If a verified complaint is handled on an informal basis, there shall be a meeting with the individual, which shall be attended by the Chief Administrative Officer and the Chief of the Medical Staff. At that meeting, the individual who has been alleged to have engaged in improper conduct shall be advised of the nature of the complaints and shall be given an opportunity to respond to the allegations raised. The identity of the complainants shall not be revealed at this time unless, in the direction of the Chief Administrative Officer and the Chief of the Medical Staff, they deem it appropriate to do so and the individual in question has been advised that any retaliation against the complaint will not be tolerated.

7. If, at the conclusion of this meeting, it is believed that the alleged improper conduct did in fact occur, MMCOR shall take appropriate corrective and/or preemptive action, which shall include, but not be limited to, any or all of the following:

    a. The physician involved shall be informed that the improper conduct violates federal law and will not be tolerated by MMCOR.

    b. The physician involved shall be informed that the improper conduct must cease immediately and, if appropriate, an apology must be offered to the complaint involved.

    c. MMCOR may determine that the physician involved is not permitted to enter the MMCOR for an appropriate period of time depending on the circumstances of the complaint.

    d. The physician involved shall be informed that any further incidents of a similar nature will result in the individual not being permitted to enter MMCOR and the initiation of formal disciplinary action in accordance with the Medical Staff Bylaws.

    e. Depending on the specific circumstance and the matters discussed during this meeting, the Chief Administrator Officer and the Chief of the Medical Staff may also determine to immediately initiate formal disciplinary action in accordance with the Medical Staff Bylaws.

8. Minutes shall be kept of the meeting.

9. If the individual has agreed to stop the improper conduct, the meeting shall be followed up with a formal letter of reprimand and admonition to be placed in his or her confidential file. This letter shall also set forth those additional actions, if any, that result from meeting.

10. If the individual refuses to agree to stop the conduct immediately, such refusal shall result in notice that he or she will not be permitted to enter MMCOR facilities until such agreement is obtained. Such exclusion is not a suspension of clinical privileges, even though the effect is the same. Rather, the action is taken because the MMCOR has no choice but to protect its employees and others on its premises from improper conduct.

11. Any further reports of harassment, after the individual has agreed to stop the improper conduct, shall result in an immediate review by the Chief Administrative Officer and Chief of the Medical Staff (or their designees). If the review results in a finding that further improper conduct took place, the physician shall be excluded from MMCOR and formal disciplinary action in accordance with the Medical Staff Bylaws shall be instituted. Should this action entitle the individual to request a hearing under the Bylaws, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

CONFIDENTIALITY POLICY

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

POLICY STATEMENT:

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

1. All peer review documents must be clearly marked: "Confidential pursuant to TCA 63-6-219."

2. Peer review records should not be duplicated, nor placed in any other hospital files other than those referenced above.

3. If copies are disseminated to committee members, a mechanism to retrieve and dispose of such copies must be enforced.

4. Peer review records or documents prepared for review by peer review committees should never be included in patient medical records.

5. Only documents of peer review committees that are established or authorized by the hospital or medical staff bylaws will be protected. Therefore, it should be clearly documented that any adhoc committee to conduct a particular investigation or review is acting on behalf of the hospital, and pursuant to the medical staff bylaws.

6. Any protection afforded by the Tennessee statute regarding medical staff peer review activities will be lost if confidentiality is not maintained.

7. This policy applies to members of medical staff committees, departments, and any other medical staff members or hospital employees who may attend meetings or who have access to committee reports, recommendations or minutes which address peer review matters.

8. Access to confidential files is limited to the following persons and conditions:

   a) Chief of Staff and medical officers – any individual or committee files
   b) Chiefs of service – individual or committee files related to the respective service
   c) Chair and members of Credentials Committee – any individual or committee files
   d) Administrator/CEO – or his designated representative
   e) Surveyors, inspectors with a need to know as approved by chief of staff and administration and hospital attorney as appropriate, exs.: TJC surveyors, state licensing surveyors, etc.
   f) Individual physicians seeking access to their personal confidential files during regular business hours, upon 24 hours advance notice, and in the presence of a medical staff officer or a designee of the Chief of Staff.

9. CONTENTS OF INDIVIDUAL CREDENTIALS FILES AND COMMITTEE MINUTES/RECORDS:

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

10. DELETIONS/CORRECTION OR ADDITIONS: Deletions from confidential files are not permitted. Corrections or additions should be made according to the policies outlined for corrections or additions to the patient medical record.

11. SANCTIONS: The following sanctions may be invoked for breaches of the signed confidentiality agreement regarding peer review activities.

    a) dismissal from committee assignments and/or medical staff office;
    b) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);
    c) disciplinary action as deemed appropriate by the MEC pursuant to the Hospital's Credentialing Policy; and/or
    d) other appropriate legal action

12. CONFIDENTIALITY AGREEMENT: All medical staff officers, section chiefs, medical staff committee members (MD and non-MD that are involved in peer review activities), and administrative officers shall sign and comply fully with a confidentiality agreement. Copies of such agreements will be maintained in the medical staff office.

TELEMEDICINE

Definitions

TELEMEDICINE

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

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

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

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

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

MEDICAL RECORDS

This policy applies to all members of the Medical Staff holding clinical privileges. The policy also applies to advanced practice professionals (APPs).

I. General Keeping of the Medical Record

A. Completion and Signature Requirements

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

2. All entries shall be dated, timed and authenticated by the author of the entry.

3. A medical record is defined as complete at the expiration of thirty (30) days post discharge and all required documentation and authentication are present. The medical record is then determined to be a Closed Medical Record.

4. All clinical entries shall be accurately timed, dated and authenticated by signature, identifiable initials, or computer key. A rubber stamp of a printed name may be used to clarify a signature that might otherwise be illegible.

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

5. A list of unapproved/unacceptable abbreviations is identified below. Other abbreviations may be used. If the abbreviation is unclear, the author is to be contacted and the abbreviation clarified then documented within the record. Please refer to the Covenant Health policy on abbreviations for complete information.

"Do Not Use" Abbreviations include:

Abbreviation	**Preferred Term**
U (for unit)	"unit"
IU (for international unit)	"international unit"
Q.D. (once daily) Q.O.D. (every other day)	"daily" and "every other day"
Trailing zero (3.0 mg) Lack of leading zero (.3 mg)	Do not use 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	"morphine sulfate" or "magnesium sulfate"

B. APP Entries / Patient Care Requirements

1. APP's may perform daily rounds under the supervision of the physician. Evidence of daily communication between the supervising physician and APP is required in the medical record. A supervising physician may choose for their APP (NP or PA) to perform daily rounds. The APP will function under the direct supervision of the collaborating physician/group. The phrase "under the direct supervision of a physician" shall be construed as a periodic evaluation and clinically appropriate follow-up of the medical plan of care. Factors influencing the frequency of this evaluation include the patient's condition during the course of the medical treatment and the patient's ability to understand his/her care. The supervising physician must be readily available for in person consultation upon the request of any patient under the care of a physician-directed health care team.

2. Supervising physicians are required to co-sign the following APP entries no later than 30 days post discharge, except where noted otherwise.
    a. discharge summary
    b. history and physical
    c. consults
    d. admission order

3. A physician co-signature is not required for APP orders or daily progress notes.

4. APP's are responsible for completion of their documentation and signature requirements, including their own verbal/telephone orders.

C. Documentation by Medical Students, Interns and Residents

1. Charting guidelines for these participants are as follows:

	History & Physical Examinations	**Progress Notes**	**Orders**	**Discharge Summary**
Medical Students	Documentation only in electronic student documentation form. This documentation is not part of the permanent record.	Documentation only in electronic student documentation form. This documentation is not part of the permanent record.	Medical students may not place orders.	Documentation only in electronic student documentation form or paper form.
Residents	May perform with follow-up note from attending physician within the next 24-hours	May create with the attending to co-sign on the next visit.	May place orders.	May create or dictate with co-signature required.

D. Administrative Closure of Medical Records

1. 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 or other reasons.

2. HIM will make all reasonable attempts to complete every record, however, in the event a provider is no longer available, the record will be administratively closed. The appropriate Committee will be notified of all closed records.

II. Content of the Medical Record

A. 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:

1. 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.

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

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

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

5. Emergency care provided to the patient prior to arrival, if any;

6. The record and findings of the patient's assessment;

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

8. The reason(s) for admission or treatment;
9. The goals of treatment and the treatment plan; Evidence of known advance directives;
10. Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy, including explanation of risks and benefits of the procedure/treatment and of the alternatives to the procedure/treatment;
11. Diagnostic and therapeutic orders, if any;
12. All diagnostic and therapeutic procedures and tests performed and the results;
13. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
14. Progress notes made by the medical staff and other authorized individuals;
15. All reassessments, when necessary;
16. Clinical observations, including the results of therapy
17. The response to the care provided;
18. Reports of all consultations provided;
19. Every medication ordered or prescribed for an inpatient;
20. Every dose of medication administered and any adverse drug reaction;
21. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
22. All relevant diagnoses established during the course of care; and
23. Conclusions at termination of hospitalization
24. Any referrals/communications made to external or internal care providers and to community agencies.

B. History and Physical

1. 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 an appropriately credentialed practitioner with privileges at this hospital.
2. The history and physical must be created 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.
3. H&Ps created within 30 days prior to admission must be updated by an appropriately credentialed practitioner with privileges at the hospital to include an examination for changes in the patient's condition. This update must occur within 24 hours after the admission or registration and prior to any surgery or procedure requiring anesthesia services.
4. Please note that a History and Physical must be signed (or cosigned, as appropriate) by the physician. The physician's signature on the H&P update does not satisfy the requirement for an H & P Update as outlined above. Both must be signed or cosigned.
5. Documentation of the history and physical, completed and updated as required herein, must be documented in the patient's record prior to any procedure involving risk and all procedures requiring anesthesia services.
6. With the exception of emergencies, patients shall not be taken to the operating room unless a compliant history and physical examination report appears in the record. In cases of emergency surgery, a brief admission note and electronic health record or written evidence that a history and physical examination report has been recorded.

7. The H&P must contain, at minimum, the following:
    a. chief complaint;
    b. details of the present illness;
    c. allergies and current medications, including supplements;
    d. when appropriate, assessment of the patient's emotional, behavioral, and social status;
    e. relevant past, social, and family histories;
    f. pertinent review of body systems;
    g. appropriate physical exam as dictated by patient's clinical presentation or anticipated procedure to include, at a minimum, a documented examination of the heart and lungs; and
    h. conclusions or impressions, assessment and plans for treatment.

8. Documentation of informed consent, when applicable and appropriate

9. OB Records
    a. Obstetrical medical records shall include prenatal information. A durable, legible original or reproduction of the prenatal record is acceptable for use as the H&P, provided the patient has been seen within 30 days of admission.
    b. If a patient has a scheduled C-section, the H&P update process applies as outlined previously in this policy.

10. Minimally invasive procedures
    a. Procedures listed in Appendix A do not require an H&P unless anesthesia or moderate sedation is used. Moderate sedation as defined by CMS is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulations.
    b. A post procedure progress note / brief op note must be documented immediately after the procedure and must include:

        1) procedure performed
        2) pertinent findings
        3) estimated blood loss, if any
        4) specimens removed, if any
        5) complications, if any

    c. Note that if the full operative/procedure report is created, immediately available and signed immediately after the procedure, the immediate post-op note (aka Brief Op Note) is not required.

11. Recurring 'outpatient in a bed' visits for infusions, transfusions and chemotherapy on stable patients require an updated progress note at a minimum of once per year.

C. Consultation Reports
1. Contain a recorded opinion by the consultant that reflects the examination of the patient and review of the patient's medical record.

D. Operative Reports
1. Must be recorded immediately following the surgical or invasive procedure, before the patient is moved to the next treatment area.

2. Must be recorded by the person who performed the procedure.

3. Shall contain:

    a. the date of the procedure
    b. preoperative and postoperative diagnoses
    c. the procedure(s) performed
    d. a description of the procedure

e. findings
f. the technical procedures used
g. specimens removed, if any
h. estimated blood loss, if any
i. complications, if any
j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
k. the name of the primary surgeon and any assistants

4. Postoperative Progress Notes / Brief Op Note
    a. In the event the full operative report has not been recorded, a postoperative progress note / brief op note shall be recorded by the surgeon immediately following the procedure and prior to transfer to next level of care. Note that if the full operative report is created immediately after surgery using front end dictation, the postop progress note / brief op note is not needed.
    b. Required elements
        1) The procedure performed
        2) Description of the procedure
        3) Complications, if any
        4) Estimated blood loss, if any
        5) Findings
        6) Specimen(s) removed, if any
        7) Name of surgeon and any assistant(s)
        8) Postoperative diagnosis

E. Anesthesia Documentation Requirements
1. Pre-Anesthesia Evaluation
    a. Must be completed and documented by an individual qualified to administer anesthesia, performed within 48 hours prior to surgery or a procedure.
    b. Required elements
        1) Pre-procedural education
        2) Patient's condition immediately prior to induction of anesthesia.

2. Post Anesthesia Evaluation
    a. Shall be documented by a physician or CRNA qualified to administer anesthesia
    b. Must be performed after the patient's recovery from anesthesia and no later than 48 hours following the procedure
    c. Required elements
        1) Respiratory function, including respiratory rate, airway patency, and oxygen saturation
        2) Cardiovascular function, including pulse rate and blood pressure
        3) Mental status
        4) Temperature
        5) Pain
        6) Nausea and vomiting
        7) Postoperative hydration

F. Diagnostic and Therapeutic Orders
1. Must be
    a. Typewritten, computer-generated, or handwritten in ink
    b. Dated, timed and signed by the ordering provider
    c. Clear and legible

2. Verbal and telephone orders
    a. Should be used only when absolutely necessary
    b. Must be cosigned within 14 days (current law and regulation) following the 'read back and verify' process.

1) Must be cosigned by either the ordering provider or another provider responsible for the care of the patient.
2) If the 'read back and verify' process is not followed, the orders must be cosigned within 48 hours.

c. Please refer to Covenant Health's policy on Telephone and Verbal Orders for complete and detailed information.

3. Other persons listed below may take orders limited to their specific license, training and function.
   a. Physical Therapist
   b. Physical Therapy Assistant (PTA)
   c. Occupational Therapist
   d. Occupational Therapy Assistant (OTA)
   e. Psychologist
   f. Respiratory Technologist
   g. Respiratory Therapist
   h. Speech Therapist
   i. Pharmacist
   j. Radiology Technologist
   k. Ultrasonographers
   l. Nuclear Technologist
   m. Dietitian
   n. Sleep Techs
   o. Neuro Techs

G. Progress Notes
1. Must be recorded by an appropriately credentialed provider on a daily basis or may be documented more frequently based upon patient condition.
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.

H. Discharge Summary
1. Required for all inpatient and observation stays. In the event of a death, a Death Summary/Record of Death serves as the discharge summary.
2. Required anytime the patient stays after midnight due to clinical condition (e.g., after day surgery when clinical condition unexpectedly changes)
3. The provider who writes the discharge order is responsible for the discharge summary.
   a. When the discharge summary is dictated by the APP, the APP must include the name of the physician who should be flagged to cosign the report.
4. Must be in the record no later than 30 days post discharge
5. Required elements
   a. Reason for admission
   b. Principal diagnosis
   c. Secondary and chronic diagnoses that are treated/monitored, and whether the condition was new or present on admission
   d. Any complications and co morbidities
   e. Operative procedures performed
   f. Pertinent lab, radiology, test results and physical findings
   g. Course of treatment
   h. Condition at discharge
   i. Disposition
   j. Instructions given at discharge
   k. Final diagnosis without abbreviations or symbols
6. A short stay discharge summary will be accepted for stays of less than 48 hours, provided the stay was uncomplicated. The following elements are required:

a. Outcome of the hospitalization
b. Plans for follow up care
c. Discharge Disposition

I. Coding Queries

1. Coding queries are necessary for complete and accurate coding and core measure abstraction. Unanswered queries are treated like other chart deficiencies. Providers may be suspended if these are left unanswered as addressed under Section III of this policy.

Access to the Medical Record

1. All patient records are 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 and in accordance with Covenant Health's policies.

2. Free access to all medical records of all patients shall be afforded to medical staff members in good standing, their extenders and students for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. *Access must be in accordance with Covenant Health's privacy and security policies, and includes only those patients for which the provider has a legitimate treatment relationship.*

III. TIMELINESS

In all cases the medical record shall be completed within 30 days following patient discharge or the physician/provider will be subject to the suspension process. APP's who are delinquent in completing medical records will not be allowed to assist their sponsoring physician(s) in the hospital until all delinquent records have been completed.

A. Notification of Providers

1. Providers shall be notified of all incomplete medical records on a regular basis, no less than monthly. Incomplete records must be completed prior to the date of suspension in order to avoid suspension of elective admission privileges.

B. Failure to Complete Records – Automatic Suspension

A suspension for incomplete medical records is considered to be administrative in nature and is not reportable to the National Practitioner Data Bank. This type of suspension is not related to professional competence or conduct that could adversely affect the health or welfare of the patient.

1. Failure to complete records by the suspension deadline results in an automatic administrative suspension of privileges.

2. HIM sends written notification of suspension to the physician's practice by fax or email. The notification includes the requirement for the physician to arrange for appropriate coverage for patients by another medical staff member with like privileges.

3. The automatic administrative suspension includes all admitting privileges and scheduling of any new procedures. The physician on suspension may continue to care for patients currently admitted to the physician's service for up to 15 days from the date of suspension. Admissions and procedures that have been scheduled prior to the date of suspension will be honored for up to 15 days after the date of suspension.

4. A suspended physician may continue to take emergency call and admit and care for patients in emergency situations.

5. 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.

6. Reinstatement of these privileges is allowed immediately upon completion of all delinquent record(s). Suspension of these privileges cannot be based upon a minimum or maximum

numbers of records to be completed. Any and all delinquent records are expected to be completed.

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

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

8. If a physician has been suspended for a third time in the calendar year, all clinical privileges are automatically relinquished until all delinquent medical records are completed. The automatic relinquishment is not grounds for a fair hearing and is not reportable to the NPDB. *(Refer to Credentials Policy, 6.F AUTOMATIC RELINQUISHMENT)*

9. Reinstatement from the automatic relinquishment may be requested upon completion of all delinquent medical records. The request is to be submitted through Medical Staff Services. Payment of a fine may be required as determined by the MEC.

10. If the physician does not complete all delinquent records within 60 days after the automatic relinquishment is in effect, the matter will be referred to the MEC and may be considered an automatic resignation from the medical staff.

APPENDIX A

I. Minimally invasive procedures that DO NOT require an H&P

A. 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 minimum:
   1. the name of physician performing procedure,
   2. procedure performed, and
   3. any other pertinent medical findings or events.

B. Minimally invasive procedures are defined as all:
   1. Apheresis
   2. Arthrocentesis, joint injections, arthrograms
   3. Aspiration
   4. Biliary tube change
   5. Blood patch
   6. Bone marrow biopsy
   7. Breast biopsy if no sedation
   8. Cardiac Stress Test
   9. Central venous line, Q Port flush
   10. Coronary CTA
   11. EEG
   12. Epidural steroid injections or diagnostic injections
   13. Esophageal motility studies, rectal motility studies
   14. Fetal non-stress test
   15. Fistulogram
   16. Gastrotomy tube replacement
   17. Image guided biopsy, image guided drainage, image guided aspiration
   18. Labor checks
   19. Manometry
   20. Myelograms, lumbar punctures
   21. Nephrostogram
   22. Nerve root blocks, sympathetic blocks, IV regional blocks
   23. Newborn circumcisions
   24. Paracentesis, thoracentesis
   25. PEG tube replacement
   26. Percutaneous transhepatic choangiogram
   27. Perma cath removal
   28. PFT
   29. pH study
   30. PICC line placement
   31. Pill cam
   32. Spirometry
   33. Tilt table test
   34. Venogram

II. Procedures that DO require H&Ps include, but are not limited to:

A. Any procedure involving sedation requires an H&P (including radiology).

B. Angiogram

C. Device implants (e.g., pH probe)

D. Heart catheterization

E. Chemotherapy, blood transfusions and drug infusions

   1. Stable patients receiving any of the above on a regular basis require an H&P or updated progress note once a year.

INFECTION CONTROL

Obligations of the Medical Staff:

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

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

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

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

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

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

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

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

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

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

PHYSICIAN NOTIFICATION OF SIGNIFICANT TRENDS OF INCREASED POST PROCEDURE INFECTION RATES

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

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

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

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

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

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

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

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

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

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

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

DIRECTOR OF ANESTHESIA SERVICES

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

DIRECTOR OF NUCLEAR MEDICINE SERVICES

Nuclear Medicine 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 radiology with nuclear medicine privileges; 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.

DIRECTOR OF RESPIRATORY CARE/CRITICAL CARE SERVICES

Respiratory/Critical Care 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 internal medicine with critical care training, or pulmonary medicine; 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.