Parkwest Medical Center

Medical Staff Rules and Regulations

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PARKWEST MEDICAL CENTER STAFF RULES AND REGULATIONS
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Parkwest Medical Center

Medical Staff Rules and Regulations

I. GENERAL

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

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

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

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

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

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

6. **"SUPERVISING/COLLABORATING PHYSICIAN" is defined in the System Credentials Policy as a medical staff member with clinical privileges who has agreed in writing to supervise or collaborate with an APP and to accept full responsibility for the actions of the APP while he or she is practicing in the Hospital. Pursuant to this policy and the Tennessee state regulations, physicians (MD/DO) may supervise the following APP's – NP, PA, CRNA, midwife; and a podiatrist (DPM) may supervise a PA.**

II. ADMISSIONS AND DISCHARGES

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

2. **At the time of admission of a patient, the responsible physician shall provide the admitting clerk with any and all information necessary to insure protection of other patients and/or hospital employees from those who are a source of any danger whatsoever. The responsible physician**

shall also provide the admitting clerk with the provisional diagnosis, a statement whether the case is medical or surgical in nature, as well as the classification based upon the relative urgency of the condition for which admission is sought. All members of the medical staff shall comply with the medical staff approved regulations on temporary suspension of admission privileges and the "Admission Priority" policy. Compliance will include not admitting patients under practice associates' names while under suspension and adhering strictly to definitions of admission urgency in the Admission Priority policy.

3. On admission and during stay Practitioners shall provide:

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

(b) Supportive services.

(c) Discharge planning.

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

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

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

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

III. MEDICAL RECORDS AND DOCUMENTATION

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. <u>APP Entries / Patient Care Requirements</u>

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. <u>History and Physical</u>

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 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

a. 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, with the exception of hospice patients (see bullet 3 below).
2. Shall denote the patient's status, detail of any changes, and the condition of the patient.
3. For inpatient hospice patients, a physician progress note must be recorded, at a minimum, once a week. If a change in plan of care is necessary, such as diagnostic testing or medication orders, this will be communicated to the primary physician for evaluation and ordering.

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. Epidural steroid injections or diagnostic injections
2. Nerve root blocks, sympathetic blocks, IV regional blocks
3. Image guided biopsy, image guided drainage, image guided aspiration
4. Myelograms, lumbar punctures
5. Arthrocentesis, joint injections, arthrograms
6. Central venous line, Q Port flush
7. Newborn circumcisions
8. EEG
9. Esophageal motility studies, rectal motility studies
10. Labor checks
11. Manometry
12. Tilt table test
13. Breast biopsy if no sedation
14. Apheresis
15. Aspiration
16. Biliary tube change
17. Blood patch
18. Coronary CTA
19. PFT
20. Fistulogram
21. Gastrotomy tube replacement
22. Nephrostogram
23. Paracentesis, thoracentesis
24. PEG tube replacement

25. Perma cath removal
26. Percutaneous transhepatic choangiogram
27. Pill cam
28. PICC line placement
29. Spirometry
30. Stress test
31. Ureteral stent placement
32. Venogram
33. pH study
34. Bone marrow biopsy

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

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.

IV. CONSULTATIONS

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

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

3. All requests for consultations shall state the reason(s) for the consultation and pertinent patient information that will be meaningful for the consulting provider. Documentation in the record of meaningful history and physical findings that support the need for consultation should be included.

4. If circumstances are such that the consulting physician determines that the consultation is not required for patient care, the consultation shall not be performed and the reason for such shall be promptly documented in the progress notes of the patient's clinical record. It is recommended such decision be discussed with the provider requesting the consultations.

5. All requests for consultation shall state the time frame within which the consult should be accomplished. There are three (3) established time frames for providers to respond to requested consultations.

   INPATIENT/OBSERVATION CONSULTAIONS:

   a) STAT – responds to clinical situations within 3 hours of being called. Given the urgency of STAT consultations, the requesting provider will make direct contact with the consulting provider to discuss the patient's clinical situation and urgency for the consultation. It is expected STAT consults will be seen within three (3) hours unless a different timeline is determined through Provider to Provider communication.

   b) ASAP – responds within the mutually agreed upon timeline, not to exceed 24 hours. Given the urgency of ASAP consultations, the requesting provider will make direct contact with the consulting provider to discuss the patient's clinical situation and urgency for the consultation. It is expected that ASAP consults will be seen within the mutually agreed upon timeline.

   c) Routine – responds within 24 hours of consult being called.

   d) As an outpatient

   EMERGENCY DEPARTMENT CONSULTATIONS; - Given the urgency of STAT consultations in The Emergency Department, the requesting physician will make direct contact with the consulting Physicians to discuss the patient's clinical situation and urgency of the matter that necessitates an immediate response. Otherwise, it is expected that all other ED consults will be given a response by the consulting provider in the form of a phone call to the ED as soon as possible but no greater than sixty (60) minutes from time of consult. It is expected that consults will be seen, when necessary, as soon as possible but within a mutually agreed upon timeline determined through provider-to-provider communication.

6. The ED Call Schedule will be utilized for ED call and in-house unattached patients, unless a specific physician is requested.

7. Failure to follow these Rules and Regulations may result in a provider's referral to the Professional Quality and Peer Review Committee.

V. ORDERS, TREATMENTS AND MEDICATIONS

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

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

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

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

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

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

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

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

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

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

VI. SELF PRESCRIBING AND TREATMENT FOR FAMILY MEMBERS

Self-Prescribing

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

Immediate Family

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

2. **Appropriate consultation should be obtained for the management of major or extended periods of illness**

3. **No schedule II, III or IV controlled substances should be dispensed or prescribed except in emergency situations**

4. **Records should be maintained of all written prescriptions or administration of any drugs**

VII. SURGICAL PROCEDURES: OPERATING ROOM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20. **Invasive procedures are defined as procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, caudal blocks, epidurals, arteriograms and implantations, and excluding venipuncture and intravenous therapy. Documentation of the need for the invasive procedure will be supplied by either the referring physician or the operating physician. The referring or operating physician will supply documentation of the need for the invasive procedure.**

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

VIII. EMERGENCY SERVICES

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

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

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

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

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

IX. SPECIAL SERVICES AND SUB-SPECIALTIES

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

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

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

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

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

(a) Dentist's responsibilities:

(1) A detailed dental history justifying hospital admission.

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

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

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

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

(6) Discharge summary.

(b) Physician's Responsibilities:

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

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

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

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

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

(a) Podiatrist's responsibilities

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

(2) A detailed history justifying hospital admission.

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

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

(5) Progress notes.

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

(b) Physician's responsibilities:

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

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

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

X. PHYSICIAN WELLNESS POLICY

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

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

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

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

XI. INAPPROPRIATE BEHAVIOR POLICY

GENERAL POLICY OBJECTIVE

It is the policy of this Hospital and its governing board that all individuals within its facilities, and all individuals engaged in activities on behalf of the Hospital or Hospital patients should be treated courteously, respectfully, and with dignity. It is the objective of this Hospital to provide optimum care for Hospital patients and to prevent and eliminate inappropriate conduct that may disrupt Hospital operations and/or interfere with optimal patient care.

POLICY REQUIREMENTS

All health care practitioners and employees of health care practitioners exercising clinical privileges in this Hospital shall refrain from engaging in "inappropriate behavior" as defined by this policy. Individuals who are employed by the Hospital shall be governed by comparable personnel policies applicable to employees and not by this policy.

No employee of the Hospital, no medical staff appointee or employee of a medical staff appointee, shall be subject to sanction or discipline for reporting instances of "inappropriate behavior" to any member of Hospital management, Medical Staff Department Chairman, or Chief of Staff as long as such reporting is done confidentially and without further publication or discussion of the report to others, except to the extent necessary to prevent recurrences or to protect the safety of any individual on Hospital premises. Instances of violence, threats of violence, carrying weapons, and/or intoxication shall be reported immediately to Hospital Security.

DEFINITION OF "INAPPROPRIATE BEHAVIOR"

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

1. **Sexual or other harassment of an individual or individuals, meaning offensive behavior directed toward any individual or individuals that is based on race, color, religion, sex, pregnancy, national origin, age or disability.**
2. **Violence, meaning behavior intended to cause harm to either person or property or behavior bearing a substantial possibility of causing such harm, whether intended or not.**
3. **Threats of violence.**
4. **Carrying weapons.**
5. **Alcohol intoxication or use of any illegal drug or inappropriate use of controlled substances while on hospital property.**
6. **Inappropriate and disrespectful verbalization with respect to an individual or individuals.**

PROCEDURE

The procedure herein described envisions a three-tiered approach as follows: (1) the first grievance is dealt with in a collegial manner BUT a report of the meeting between the physician and his/her department chairman is placed in the physician's quality file noting the subject discussed and the date/time of the meeting; the physician has the right to file a written rebuttal; (2) the second "tier" is used for a repeated grievance (same or different category of behavior); in this instance both the chairman of the department and the Chief of Staff meet with the physician; a report is generated and is placed in the physician's quality file and the physician has the right to file a written rebuttal; (3) the third tier is used for either the first grievance of an episode felt to warrant bypassing of either the first two tiers and involves the (enlarged) Quality Committee and a report will be placed in the physician's Quality File; the physician has the right to file a written rebuttal. Information placed in a physician's Quality File remain until the time of his/her next reappointment at which time they may be destroyed unless, at the discretion of the Chief of Staff and then chairman of his/her department, such information is felt worthy of trending or otherwise preserving. Any decision to remove information placed in a physician's Quality File must be approved by a simple majority of the Quality Committee. All such files are protected under the provisions of peer review and are regarded as confidential.

Any physician or employee may report concerns regarding inappropriate physician behavior. Physicians will be notified whenever a grievance is filed against him/her. Employees should direct such concerns to their Manager, or House Supervisor, if the Manager is not available. Physicians should contact the Chairman of the appropriate Medical Staff Department. Concerns expressed by a patient or visitor should be directed to the Manager where the patient is receiving care, or the Hospital Patient Representative, who should in turn contact the Manager. The response process to perceived inappropriate physician behavior should be promptly initiated by the individuals designated above (Manager, House Supervisor, or Medical Staff Department Chairman). If the Medical Staff Coordinator becomes aware of any such behavior, the Medical Staff Office shall promptly contact the appropriate Medical Staff Department Chairman. Confirmed reports of such grievances should be addressed as presented above. Some situations may be serious enough to warrant bypassing steps.

Violations of this policy shall be dealt with in accordance with the Medical Staff Bylaws. However, repeated instances of "inappropriate behavior" shall be deemed grounds for summary or precautionary suspension, and removal from the premises, under the authority of the Bylaws. Nothing herein shall prohibit collegial or informal attempts to address "inappropriate behavior".

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

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

1. Tier One

After receiving a grievance found to be credible, the Chairman of the appropriate department should facilitate discussion with the physician involved to resolve the issue. The Chief of Staff is to be informed before the physician is approached by his/her department chief. In this step, and all subsequent steps, the individual who reported the grievance should be informed that his/her concern has been addressed and encouraged to inform the individual handling the grievance of any future concerns. The discussion between the department chief and the physician is to be collegial and limited to the facts as reported. The chairman shall initiate such discussion and emphasize that any inappropriate conduct must cease. A report is placed in the physician's Quality file. In most instances, this initial approach should be collegial and is designed to be helpful to the physician and the Hospital; however, depending on the severity of the behavior, a more serious and formal approach may be needed. After this discussion, the matter is closed unless further written reports are received.

2. Tier Two

If another grievance is reported and found to be credible, either through the hospital or medical staff, the following procedure is to be followed. If submitted by hospital staff, the Chief Nurse Executive is to receive the written report, if by the medical staff, to the chairman of the department. The Chief of Staff is then to be notified. The Chief of Staff along with the chairman of the appropriate department then meet with the physician. This meeting constitutes a more serious step than tier one. The physician is again reminded of his/her responsibilities and the specific behavior(s) and event(s) are discussed. A firm understanding must be assured by the physician re: his obligations not to engage in inappropriate behavior(s). This understanding is documented by letter to the physician and a copy of the report of the meeting and the letter to the physician are both placed in the physician's Quality file. The physician is informed that he/she may write a letter of rebuttal which is also placed in his/her Quality file. If there are no further reports, no further action is required.

3. Tier Three

This is reserved for egregious behavior (in which case tiers 1 and/or 2 may be skipped) or for repeated episodes of disruptive behavior. In this instance, the report is submitted both to the chief of the appropriate department and the Chief of Staff. This matter is discussed at the next regular (or called) meeting of the Quality Committee. For the purposes of discussing behavioral issues, the Quality Committee will consist of the chair-elect of each clinical department plus the Chief of Staff, Chief of Staff-elect, the VP Operations of the Hospital, and the Chief Nurse Executive. The physician may or may not be invited to that meeting. After discussion by the full committee, a decision will be made regarding appropriate action (under the Bylaws) and whether to invite the physician to the next regular (or called) committee meeting. The physician will be informed that he/she may bring another physician of his choosing, with the understanding that this second physician must be a member of the medical staff and also be acceptable to the Quality Committee. The Quality Committee will determine what action is to be taken under the Bylaws and the matter will be reported to the Medical Executive Committee at its next regular (or called) meeting.

DOCUMENTATION GUIDELINES

Documentation of disruptive conduct is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. That documentation should include:

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

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

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

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

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

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

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

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

XII. PHYSICIAN QUALITY FILES:

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

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

Procedure:

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

2. **Authority to access the physician profiles is granted to those with responsibilities related to the assessment of patient care. Those granted access are: the Chief of Staff, the Chairman of the Credentials Committee, Chairman of the Quality Committee, the Chief of the Department (to members of his/her department), the individual physician (to his own), the Manager of the Clinical Effectiveness Department and Outcome Coordinators, Medical Staff Office Specialists.**

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

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

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

Data reported (when available) as follows:

TJC Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Resource Management: total admissions, total procedures, total consultations for the year

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

XIII. PSYCHIATRIC SERVICES:

Recommend adding the following:

Psychiatric Services Delivered at Peninsula

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

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

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

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

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

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

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

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

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

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

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

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

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

XIV. DIRECTOR OF ANESTHESIA SERVICES:

<u>Anesthesia Services</u>: 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.

<u>Emergency Services</u>: 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.

<u>Respiratory Care/Critical Care Services</u>:
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.

<u>Nuclear Medicine Services</u>: 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.