

**MEDICAL STAFF BYLAWS
OF
GOOD SAMARITAN HOSPITAL
August 6, 2019**

ARTICLE I. MEDICAL STAFF STRUCTURE

A. Officers of the Staff

The officers shall include:

1. Chief of Staff/Chief Medical Officer
2. Secretary

B. Qualifications

Officers must be regular members of the Active Staff at the time of the nomination and election, and must remain Active Staff members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved, although this requirement may be waived by a vote of the Nominating Committee in cases of minor infractions. The Chief of Staff must possess demonstrated competence in his/her field of practice and demonstrated qualifications on the basis of experience and ability to direct the medical-administrative aspects of Hospital and Staff activities.

C. Election and Term of Office

The Nominating Committee shall recommend a slate of officers for nomination, to be presented at the annual meeting of the Staff. Staff Officer Elections will be held every two (2) years. The Staff officers shall be elected by a simple majority of the regular Active Staff members present at the annual meeting of the Staff and shall hold office until a successor is elected and qualified. Officers shall take office on the first day of the new calendar year following election.

D. Vacancies

A vacancy in the office of the Chief of Staff shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible, following the mechanism outlined for an annual election.

E. Duties

Chief of Staff – The Chief of Staff shall serve as the chief medical officer of the Staff. The Chief of Staff's duties shall be to:

1. Aid in coordinating the activities and concerns of the Administration, the nursing and other patient care services with those of the Staff.

2. Develop and maintain in cooperation with the medical staff for credentials review, continuing education programs, utilization review, concurrent monitoring of the Staff practice, retrospective patient care audit, and quality improvement activities.
3. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Staff to the Board, the Administrator, and other officials of the Hospital for implementation of sanctions where these are required, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a staff member.
4. Call, preside at, and be responsible for the agenda of all regular and called meetings of the Staff.
5. Serve as Chair of the Medical Executive Committee and as an ex-officio member of all committees of the Staff (with no vote).
6. Attend the meetings of the Board.
7. Be responsible for the enforcement of Medical Staff Rules and Regulations and Bylaws.
8. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees except the Executive Committee.
9. Represent the views, policies, needs, and grievance of the Medical Staff to the Governing Body and the Administrator.
10. Be a spokesperson for the Medical Staff to the community (i.e. public relations).

F. Removal

An officer of the Staff may be removed by two-thirds (2/3rds) vote of the regular Active Staff members eligible to vote for Staff officers. Removal may be based only upon failure to perform the duties of the office held as described in these Bylaws or upon failure to otherwise adhere to the requirements of these Bylaws.

ARTICLE II. CATEGORIES OF MEMBERSHIP

A. Active Staff

1. Active staff members will be expected to maintain a minimum of thirteen admissions, outpatient procedures or consultations per year; or be regularly involved in medical staff activities as defined by the medical staff.
2. Active Staff members are regularly responsible for patient care in the hospital, maintain a full-time functional office for the practice of medicine and consultation in the Greene County area, and have a sixty (60) minute physical response time to the Hospital as to accomplish, as nearly as possible, appropriate continuity of care to patients in the Hospital and regular involvement by Staff members in patient care and staff functions.

3. Active Staff members may vote in all general and special meetings of the Medical Staff, and applicable committee meetings. All Active Staff members are eligible to hold office on the Medical Staff. All active staff members are encouraged but not required to attend staff meetings. Attendance requirements may be imposed by the Chief of Staff under special circumstances.
4. Hospital-based physicians whose full-time functional office will be Good Samaritan Hospital shall be appointed to the Active Staff, and will not be required to meet the sixty (60) minute physical response time.
5. Reappointment Considerations:

All members of the Medical Staff are responsible for demonstrating their current clinical competence for the privileges they request and their ability to provide safe, appropriate care. Members who are clinically active at Good Samaritan Hospital are subject to the Hospital's ongoing and focused professional practice evaluations, the results of which assist the Medical Staff Leaders and the Board in determining competence at the time of reappointment.

For members who are not clinically active, the professional practice evaluation data is limited and additional information is necessary to facilitate the reappointment process. Therefore, any Active Staff member who has fewer than 24 patient contacts during his/her two-year appointment term must present the following information in order to be eligible to request reappointment to the Active Staff:

- (i) two evaluations from other physicians who are personally knowledgeable about the member's qualifications and competence, who are not members of the same group practice, and at least one of whom is clinically active at St. Mary's Hospital. These physicians must complete the Confidential Physician Evaluation Form provided by the Hospital; and
- (ii) such additional quality data and other information as may be requested by the Medical Staff Leaders or Hospital to assist in an appropriate assessment of current clinical competence and overall qualifications for reappointment and clinical privileges (including, but not limited to, information from another hospital, ambulatory surgery center or clinic, managed care organization(s) in which the individual participates, and/or the individual's private office).

The member seeking reappointment to the Active Staff bears the responsibility and burden of ensuring that this information is provided to the Medical Staff Leaders and the Hospital in a timely manner. If this information is not provided in a timely manner, the member's reappointment application shall be considered incomplete and shall not be processed. In that event, the member's appointment and privileges will expire at the end of his/her appointment term.

B. Consulting Staff

1. Consulting staff members shall consist of specialists, Telemedicine, physicians, podiatrists and dentists. They shall not be required to maintain a minimum number of patient contacts as long as adequate documentation of current clinical competence is available from those institutions at which active staff membership is held.
2. Consulting staff members are willing and able to come to the Hospital on schedule or response as needed to render clinical services within their area of competence.
3. Consulting staff members shall be entitled but not required to attend meetings of the Medical Staff and the area of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.
4. Consulting staff members shall not be eligible to hold office on the Medical Staff, but may serve on committees.

C. Affiliate Staff

The affiliate medical staff shall consist of Physicians, Podiatrists and Dentists who do not desire to become practicing members of the Medical Staff but who wish to participate in a limited manner in the activities of the hospital. They need not meet the Qualifications for Membership, nor shall they be entitled to the rights afforded to members by the Bylaws.

Persons appointed to the Affiliate Staff may attend the professional programs of the Medical Staff. They may not be granted clinical privileges but may confer with the attending physician on patients referred for care by the Affiliate. Affiliate Staff shall not be eligible to vote or hold office nor shall they be required to attend Medical Staff Meetings. Affiliate Staff may not serve on Medical Staff Committees.

1. **Eligibility:** This category of membership shall be available to Physicians and Podiatrists who do not intend to admit or manage patients in Good Samaritan Hospital (GSH), but who:
 - a. Practice in or around the service area and utilize GSH specialists. Practicing members of the Affiliate Category must meet one of the following requirements:
 - i. Physician or Podiatrist must have previously held membership on the Medical Staff of GSH or other hospitals in the service area; or
 - ii. Physician or Podiatrist must have outstanding reputation in the GSH service area; and
 - b. Serve in a medico-administrative capacity for industry, insurance companies, etc.

2. **Credentialing:** Credentialing for applicants to the Affiliate Medical Staff consists of, but is not limited to, the following:
 - a. Practicing Physicians or Podiatrists must:
 - i. Submit a request for Affiliate membership by completing an application for appointment.
 - ii. Provide all necessary documentation to satisfy the application.
 - iii. Provide a letter of recommendation from the Administrator or designee of a hospital affiliation where membership is held, if applicable.
 - iv. Provide a letter of recommendation from the Chief of Staff or designee of their primary hospital affiliation, if applicable.
 - b. Medico-administrative Physicians or Podiatrists must:
 - i. Submit a request for Affiliate membership by completing an application for appointment.
 - ii. Provide all necessary documentation to satisfy the application.
 - iii. Provide a letter of recommendation from the Administrator or President of their firm; and Recommendation of the GSH Medical Staff and Approval of the GSH Board of Directors.

There is no implied ability to move from Affiliate to any other category of the Medical Staff. Such a move would require separate completed application.

D. Honorary Medical Staff

1. The Honorary Medical Staff shall consist of physicians who have retired from active practice or who are of outstanding reputation, not necessarily residing in the community.
2. Honorary Staff members shall not be eligible to admit patients, to exercise clinical privileges, to vote, or to hold office. They may, but are not required to, attend staff meetings, including open committee meetings and educational programs. They may, but are not required to serve on standing committees.

E. Physicians in Training

Physicians in training shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the MEC or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

NOTE: Allied Health Professionals are covered in a separate policy.

ARTICLE III. MEETINGS

A. Annual Meeting

The annual meeting of the Staff shall be one of the regular meetings. At this meeting, the retiring officers and committees shall make such reports as may be desirable and officers for the ensuing year shall be elected.

B. Regular Meetings

Regular meetings of the Staff will be held at least one (1) time per Medical Staff year at a time and place determined by the Chief of Staff. In addition to matters of organization, the programs of such meeting will include a report of actions of the Executive Committee.

C. Special Meetings

Special meetings of the Staff may be called at any time by:

1. Chief of Staff
2. The Medical Executive Committee
3. Not less than one fourth (1/4th) of the Medical Staff

Notice of special meetings shall be made in writing at least three (3) calendar days prior to the date of the meeting. At any special meeting, no business shall be transacted other than that stated in the notice of the called meeting, and a quorum as defined in Section E below shall be required.

D. Minutes

Minutes of the meetings shall be taken by the Administrative Assistant or appointee chosen by the Administrator or Chief of Staff and shall include attendance and votes on each matter.

E. Quorum: Voting Requirements

A quorum for all purposes shall consist of those regular Active Staff members present, provided that, there must be at least fifteen (15) days' prior notice of proposed amendments to the Bylaws or other major or significant (as determined by the Medical Executive Committee) items for action at the meeting. The use of proxies by Staff members is prohibited. At any meeting at which a quorum is present, business may be transacted by a majority vote of those regular Active Staff members present and voting in person or by telephone or electronic means. Only Active Staff members may participate in discussions at Medical Staff meetings, provided that, members of other categories who are present to observe may answer any questions posed by the Chair.

ARTICLE IV. HISTORY AND PHYSICAL

A comprehensive history and physical (H&P) examination shall be completed within 24 hours of admission to inpatient services by the appropriate practitioner privileged to perform H&Ps. H&P examinations by the appropriate practitioner privileged to perform H&Ps must be completed and recorded before any operative or invasive procedure is undertaken, unless the practitioner certifies in writing in the medical record, that the patient's situation is emergent, and any delay could lead to death or serious disability. H&P examinations may be completed ahead of time, though no more than 30 days prior to admission or readmission, and only by the appropriate practitioner privileged to perform H&Ps. A durable, legible copy (or original) of the report is placed in the patient's medical record and any significant changes in the patient's condition since the report was recorded are noted in the record within 24 hours of admission. In surgical cases, the provisional diagnosis shall be recorded in the preoperative note by the surgeon before operation. Appropriate screening tests based on the needs of the patient are accomplished and recorded within 72 hours prior to surgery.

History and physical examinations will include:

- A medical history with relevant chief complaint, history of present illness/condition, social and family history, inventory of systems;
- A statement of conclusions or impressions drawn from physical exam;
- Diagnosis or diagnostic impression;
- Reason(s) for admission or treatment, goal(s) of treatment and treatment plan;
- Documentation that rectal/pelvic exam was performed will be required when pertinent to admission diagnosis.

For outpatient procedures (which include operative and invasive procedures), history and physical examination includes indications for procedures, pertinent medical history, medications being taken, allergies and vital signs. Additionally, evaluation of heart and lungs is to be recorded prior to any outpatient procedure.

Any patient presenting with known or suspected conditions consistent with abuse must be assessed in accordance with state and federal law.

Podiatric physicians who have clinical privileges are also responsible for completion of the medical record on their patients. This includes a history and physical examination as permitted by their scope of licensure, operative and procedure reports and the discharge summary. They must have a complete medical history and physical recorded on the chart by a qualified physician (MD or DO) member of the medical staff, within 24 hours of admission and before any surgical procedure is performed. Podiatric physicians privileged to do so may complete a full H&P for their outpatient surgical patients with an ASA rating of I or well-compensated II. Should the patient be admitted as an inpatient, an H&P will be completed by a physician (MD or DO) member of the medical staff. For all other outpatients, a physician (MD or DO) must conduct or directly supervise the admitting H&P exam (except that portion related to podiatry).

ARTICLE V. MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

A. Medical Executive Committee

A.1. Composition

- a. The Medical Executive Committee shall include the Chief of Staff, the Medical Director of the Operating Room, the Medical Director of the Emergency Department and the Medical Director of Medical/Surgical Floor.
- b. The Chief of Staff will chair the Medical Executive Committee.
- c. The Administrator shall be an ex officio member of the Medical Executive Committee, without vote.

A.2. Duties

The Medical Executive Committee has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges. The Medical Executive Committee is responsible for the following:

- a. acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;
- b. recommending directly to the Board on at least the following:
 1. the Medical Staff's structure;
 2. the mechanism used to review credentials and to delineate individual clinical privileges;
 3. applicants for Medical Staff appointment;
 4. delineation of clinical privileges for each eligible applicant;
 5. participation of the Medical Staff in Hospital performance improvement activities;

6. the mechanism by which Medical Staff appointment may be terminated;
and
 7. hearing procedures;
- c. consulting with the Administrator on quality related aspects of contracts for patient care services;
 - d. receiving and acting on reports and recommendations from Medical Staff committees, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;
 - e. reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;
 - f. providing leadership in activities related to patient safety;
 - g. providing oversight in the process of analyzing and improving patient satisfaction;
 - h. prioritizing continuing medical education activities;
 - i. reviewing or delegating to a Bylaws Committee the responsibility to review, at least every three years, the Bylaws, Policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and
 - j. performing such other functions as are assigned to it by these Bylaws, the Board or other applicable policies.

A.3. Meetings

The Medical Executive Committee shall meet as often as necessary to fulfill its responsibilities and maintain a permanent record of its proceedings and actions.

B. Performance Improvement Functions

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

1. patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;
2. the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;
3. medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

4. the utilization of blood and blood components, including review of significant transfusion reactions;
5. operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
6. education of patients and families;
7. coordination of care, treatment and services with other practitioners and Hospital personnel;
8. accurate, timely and legible completion of medical records;
9. the use of developed criteria for autopsies;
10. sentinel events, including root cause analyses and responses to unanticipated adverse events;
11. nosocomial infections and the potential for infection;
12. unnecessary procedures or treatment; and
13. appropriate resource utilization.

C. Creation of Committees

The Medical Executive Committee may, by resolution, establish committees to perform one or more staff functions or dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed which is not assigned to an individual, a standing committee, or a special task force shall be performed by the Medical Executive Committee.

ARTICLE VI. BASIC STEPS FOR REQUIREMENTS FOR BYLAWS

The details associated with these basic steps are contained in policies.

1. Qualifications for Appointment

To be eligible to apply for initial appointment or reappointment to the Medical Staff, practitioners must have a current, unrestricted license to practice in the state and have never had a license to practice revoked or suspended by any state licensing agency; have current, valid professional liability insurance coverage; have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same; and have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care programs. Further qualifications and processes for appointment or reappointment are set forth in the Procedures Relating to Medical Staff Membership and Clinical Privileges Policy.

2. Process for Privileging

Complete applications are transmitted to the Administrator, the Chief of Staff, Medical Executive Committee and Board.

3. Process for Credentialing (Appointment and Reappointment)

Complete applications are acted upon by the Chief of Staff, Medical Executive Committee and Board.

4. Indications and Process for Automatic Relinquishment of Appointment or Privileges

Appointment and clinical privileges will be automatically relinquished if any of the following occur:

- a. failure to complete medical records, after notification by the medical records department of delinquency;
- b. licensure revocation, expiration, suspension, conditions or restrictions;
- c. DEA or state controlled substance authorization revocation, expiration, suspension, conditions or restrictions;
- d. termination, lapse or insufficiency of professional liability insurance coverage;
- e. termination, exclusion, or preclusion by government action from participation in the Medicare, Medicaid or other federal or state health care programs; or
- f. indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

5. Indications and Process for Precautionary Suspension

- a. Whenever failure to act may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the Chief of Staff, the Administrator, the Board chair, or the Medical Executive Committee will each have the authority to suspend or restrict all or any portion of an individual's clinical privileges. They may afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.
- b. A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.
- c. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself.

It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

- d. A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the Administrator and the Chief of Staff and will remain in effect unless it is modified by the Medical Executive Committee.
- e. The individual shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days.
- f. The Medical Executive Committee will review the matter within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

6. Indications and Process for Recommending Termination or Suspension of Appointment and Privileges or Reduction of Privileges

- a. The Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges following an investigation or a determination that there is sufficient information on which to base a recommendation.
- b. Indications include substandard care, treatment or management of a patient or patients; conduct disruptive to the orderly operation of the Hospital or Medical Staff, including the inability of the member to work harmoniously with others; or failure to comply with applicable ethical standards, Bylaws, policies, Rules and Regulations or a performance improvement plan.
- c. Special notice that the individual is entitled to request a hearing will be given by the Administrator. The Administrator will transmit the recommendation to the Board after the individual has completed or waived a hearing.

7. Hearing and Appeal Process, Including Process for Scheduling and Conducting Hearings and the Composition of the Hearing Panel

- a. The Administrator will give special notice. The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.
- b. The Hearing Panel will consist of at least three members, one of whom will be designated as chair. The Hearing Panel may include any combination of members of the Medical Staff who have not actively participated in the matter at any previous level, or physicians or laypersons not connected with the Hospital. Knowledge of the underlying peer review matter, in and of itself, will not preclude someone from serving on the Panel. The Panel will not include any

individual who is in direct economic competition with the individual requesting the hearing.

- c. The hearing processes will be conducted in an informal manner so as to allow a reasonable opportunity to probe the basis of the recommendation. Formal rules of evidence or procedure will not apply.
- d. A stenographic reporter will be present to make a record of the hearing.
- e. Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - 1. to call and examine witnesses, to the extent they are available and willing to testify;
 - 2. to introduce exhibits;
 - 3. to cross-examine any witness on any matter relevant to the issues;
 - 4. to have representation by counsel; and
 - 5. to submit a written statement at the close of the hearing which may include proposed findings, conclusions and recommendations.
- f. The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.
- g. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

ARTICLE VII: RULES, REGULATIONS AND POLICIES

In addition to the Medical Staff Bylaws, there shall be Rules, Regulations and Policies. An amendment to these documents may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least 14 days prior to the vote by the Medical Executive Committee. Any voting member may submit written comments on the amendments to the Medical Executive Committee.

The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have fourteen (14) days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments to the Medical Staff Rules and Regulations shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts shall be implemented.

Amendments to the Medical Staff Rules, Regulations and Policies may also be proposed by a petition signed by twenty five percent (25%) of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee.

Adoption of and changes to the Medical Staff Rules, Regulations and Policies will become effective only when approved by the Board.

ARTICLE VIII. CONFLICT MANAGEMENT

In the event there is a conflict between the Medical Staff and the Medical Executive Committee with regard to: (a) proposed amendments to the Medical Staff Rules and Regulations, (b) a new policy and procedure proposed by the Medical Executive Committee, or (c) proposed amendments to an existing policy and procedure that is under the authority of the Medical Executive Committee, a special meeting of the Medical Staff will be called in accordance with the process for calling special meetings. The agenda for that meeting will be limited to the amendment(s) or policy and procedure at issue. The purpose of the meeting is to strive to resolve differences that exist with respect to Medical Staff Rules and Regulations or policies and procedures.

If the differences cannot be resolved, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies and procedures offered by the voting members of the Medical Staff, to the Board of Directors for final action.

ARTICLE IX. AMENDMENTS

1. Amendments to the Medical Staff Bylaws may be proposed by a petition signed by twenty five percent (25%) of the voting members of the Medical Staff or by the Medical Executive Committee.
2. All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.
3. The Medical Executive Committee may present proposed amendments to the voting staff by mail or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 25% of the staff eligible to vote.
4. The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

5. All amendments shall be effective only after approval by the Board.
6. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Administrator within two weeks after receipt of a request for same submitted by the Administrator.

ADOPTION

Adopted by the Medical Staff on March 17, 2011

Adopted by the Board on March 21, 2011

Adopted by the Medical Staff on December 10, 2013

Adopted by the Board on December 16, 2013

Adopted by the Medical Staff on June 12, 2017

Adopted by the Board on June 26, 2017

Adopted by the Medical Staff on October 16, 2018

Adopted by the Board on October 29, 2018

Adopted by the Medical Executive Committee on August 6, 2019 (*grammatical revisions only*)



TITLE: MEDICAL STAFF RULES AND REGULATIONS		SEARCH WORD: Medical Staff Rules, Regulations, screening exam, order
DEPARTMENT: MEDICAL STAFF		
PRESIDENT APPROVAL: Montez Carter, FACHE	MEDICAL DIRECTOR APPROVAL: Terri Sartain, Medical Staff Services	
EFFECTIVE DATE: 9/23/2008	UPDATED: 10/23/2012, 8/28/15, 6/26/2017	

MEDICAL STAFF RULES AND REGULATIONS

PURPOSE:

The purpose of these Rules and Regulations is to promote high standards of medical and surgical care of patients of St. Mary’s Good Samaritan Hospital. Furthermore, these Rules and Regulations shall serve as a guide for accomplishing this purpose, as well as, to provide certain protections for the patient, the hospital and its personnel and physicians. Each staff member shall be required to abide by the Constitution and Bylaws of the medical staff of St. Mary’s Good Samaritan Hospital, and to assist in achieving the standards set forth by the Joint Commission on Accreditation of Health Care Organizations and other state and federal regulatory bodies.

MEDICAL STAFF RULES AND REGULATIONS:

In accordance with the Medical Staff Bylaws, the following rules and regulations are adopted. Rules and regulations adopted by the medical staff in accordance with the Medical Staff Bylaws are binding to all members of the medical staff. The collective functions of the medical staff and the independent functions of its individual members shall be accomplished in accordance with applicable state law.

MEDICAL STAFF POLICIES AND PROCEDURES:

- Policies and procedures shall be developed as necessary to implement more specifically the general principles found within the Medical Staff Bylaws and Rules and Regulations. The policies and procedures may be adopted, amended or repealed by majority vote of the Medical Executive Committee. Such policies and procedures shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.
- The Rules and Regulations relate to the role and or responsibility of members of the medical staff with clinical privileges in the care of inpatients, emergency care patients and ambulatory care patients as a whole or to specific groups as designated.

GENERAL:

- The name of this organization is the St. Mary’s Good Samaritan Hospital Medical Staff.
- The Rules relate to role and/or responsibility of members of the medical staff and individuals with clinical privileges in the care of inpatients, emergency care patients and ambulatory care patients as a whole or to specific groups as designated.
- Rules of departments or services will not conflict with each other; with Bylaws, Rules, and policies of the Medical Staff; or requirements of the Governing Body.

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ARTICLE 1

ADMISSIONS, DISCHARGE AND TRANSFER OF PATIENTS

- 1.1. Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been made by the admitting physician.
 - 1.1.1. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
 - 1.1.2. The physician shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self-harm.
- 1.2. All patients shall have an attending physician.
 - 1.2.1. In the case of a patient who applies for admission or who is an emergency patient and who has no attending physician, such patient shall be assigned to the member of the Active medical staff on duty on the service to which the illness of the patient indicates assignment.
- 1.3. The Hospital staff shall admit patients suffering from all types of diseases except severe mental disease and uncomplicated acute and/or violent alcoholics.
 - 1.3.1. Since the Hospital does not have either a psychiatric service or a substance abuse service, patients with either of these conditions can be admitted only if there are emergent coexisting medical or surgical problems.
- 1.4. Patients shall be discharged only on written* order of a physician or an authorized Allied Health Professional.
- 1.5. When patients are transferred from ICU to another unit, all orders shall be canceled and new orders shall be written by the physician.
- 1.6. Prior to transfer to a nursing home, the attending physician should reissue orders for the patient.

* **NOTE:** All references to “written” entries into the medical record set forth in these Medical Staff Rules and Regulations shall be interpreted to mean written entries, appropriately issued verbal orders, as well as computer-keyed entries into the Electronic Medical Record when the relevant portion of the record exists in electronic form. See Article 2 of these Rules and Regulations for further detail.

ARTICLE 2

MEDICAL RECORDS

Section 2.1. General:

- 2.1.1. Only authorized individuals may make entries in the medical record. Electronic entries will be entered through the Electronic Medical Record (“EMR”). In emergency situations or when the EMR is not available, handwritten entries will be legibly recorded in blue or preferably black ink. All entries must be timed, dated and signed.
- 2.1.2. The attending physician will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.
- 2.1.3. All documentation will be authenticated, dated and timed.
- 2.1.4. Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or written signatures or initials for handwritten entries. Signature stamps are not an acceptable form of authentication for written orders/entries. The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.
- 2.1.5. Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.
- 2.1.6. All records and files shall be the property of the Hospital and shall not be removed from the Hospital’s jurisdiction and safe keeping without a proper court order, subpoena, or statute requiring same. In the case of readmission of a patient, all previous records shall be available for use by the attending physician. Any physician taking charts from the Hospital without permission shall be suspended until the chart is returned, or for any additional period of time that may be determined by the Medical Executive Committee of the Medical Staff.
- 2.1.7. Resident physicians may make entries into the medical record in accordance with the specific policies and procedures that have been duly adopted by the Graduate Medical Education Committee and the Board.

Section 2.2. Content of Record:

- 2.2.1. Medical records will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.
- 2.2.2. Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. Stamped signatures are not permitted in the medical record.
- 2.2.3. All medical records will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the attending physician and the Hospital:
 - 2.2.3.1. identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - 2.2.3.2. legal status (i.e., mental competency) of any patient receiving behavioral health services;
 - 2.2.3.3. patient's language and communication needs, including preferred language for discussing health care;
 - 2.2.3.4. evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;
 - 2.2.3.5. records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
 - 2.2.3.6. emergency care, treatment, and services provided to the patient before his or her arrival, if any;
 - 2.2.3.7. admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
 - 2.2.3.8. allergies to foods and medicines;
 - 2.2.3.9. reason(s) for admission of care, treatment, and services;
 - 2.2.3.10. diagnosis, diagnostic impression, or conditions;
 - 2.2.3.11. goals of the treatment and treatment plan;
 - 2.2.3.12. diagnostic and therapeutic orders, procedures, tests, and results;

- 2.2.3.13. progress notes made by authorized individuals;
 - 2.2.3.14. medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
 - 2.2.3.15. consultation reports;
 - 2.2.3.16. response to care, treatment, and services provided;
 - 2.2.3.17. relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
 - 2.2.3.18. reassessments and plan of care revisions;
 - 2.2.3.19. complications, hospital-acquired infections, and unfavorable reactions to medications and/or treatments;
 - 2.2.3.20. discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and
 - 2.2.3.21. medications dispensed or prescribed on discharge.
- 2.2.4. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital:
- 2.2.4.1. known significant medical diagnoses and conditions;
 - 2.2.4.2. known significant operative and invasive procedures;
 - 2.2.4.3. known adverse and allergic drug reactions; and
 - 2.2.4.4. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.
- 2.2.5. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital:
- 2.2.5.1. time and means of arrival;
 - 2.2.5.2. record of care prior to arrival;

- 2.2.5.3. results of the Medical Screening Examination;
- 2.2.5.4. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
- 2.2.5.5. conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;
- 2.2.5.6. if the patient left against medical advice; and
- 2.2.5.7. a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

Section 2.3. Medical Histories and Physical Exams (“H&Ps”):

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article IV of the Medical Staff Bylaws.

Section 2.4. Progress Notes:

Progress notes giving a chronological picture and analysis of the clinical course of the patient shall be entered by the primary physician (or by a resident physician or authorized Allied Health Professional) as often as is determined by the condition of the patient, but not less than every other day.

Section 2.5. Pre-Operative Documentation:

- 2.5.1. The physician responsible for the patient’s care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.
- 2.5.2. Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:
 - 2.5.2.1. the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
 - 2.5.2.2. pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;
 - 2.5.2.3. the supervising physician or appropriately credentialed designee is in the Hospital; and

- 2.5.2.4. the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

2.6. Operative Report:

- 2.6.1. An immediate post-operative/procedure note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the surgeon. The note must record:
 - 2.6.1.1. the names of the physician(s) responsible for the patient’s care and physician assistants;
 - 2.6.1.2. the name and description of the procedure(s) performed;
 - 2.6.1.3. findings, where appropriate, given the nature of the procedure;
 - 2.6.1.4. estimated blood loss, when applicable or significant;
 - 2.6.1.5. specimens removed; and
 - 2.6.1.6. post-operative diagnosis.
- 2.6.2. In addition, a detailed operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:
 - 2.6.2.1. the patient’s name and hospital identification number;
 - 2.6.2.2. pre- and post-operative diagnoses;
 - 2.6.2.3. date and time of the procedure;
 - 2.6.2.4. the name of the surgeon(s) and assistant surgeon(s) responsible for the patient’s operation;
 - 2.6.2.5. procedure(s) performed and description of the procedure(s);
 - 2.6.2.6. description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;
 - 2.6.2.7. findings, where appropriate, given the nature of the procedure;
 - 2.6.2.8. estimated blood loss;
 - 2.6.2.9. any unusual events or any complications, including blood transfusion reactions and the management of those events;

- 2.6.2.10. specimen(s) removed, if any;
- 2.6.2.11. prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and
- 2.6.2.12. the signature of the surgeon.

Section 2.7. Discharge Summary:

- 2.7.1. A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed within 15 days of discharge:
 - 2.7.1.1. reason for hospitalization;
 - 2.7.1.2. significant findings;
 - 2.7.1.3. procedures performed and care, treatment, and services provided;
 - 2.7.1.4. condition and disposition at discharge;
 - 2.7.1.5. information provided to the patient and family, as appropriate;
 - 2.7.1.6. provisions for follow-up care; and
 - 2.7.1.7. discharge medication reconciliation.
- 2.7.2. A short-stay form or discharge progress note may be used to document the discharge summary for a patient admitted for less than 48 hours.

Section 2.8. Discharge Instructions:

- 2.8.1. Upon discharge, the attending physician, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.
- 2.8.2. Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.
- 2.8.3. The attending physician, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

- 2.8.4. When the Hospital determines the patient's transfer or discharge needs, the attending physician, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.
- 2.8.5. When continuing care is needed after discharge, the attending physician, along with the Hospital staff, will provide appropriate information to the other health care providers, including:
 - 2.8.5.1. the reason for discharge;
 - 2.8.5.2. the patient's physical and psychosocial status;
 - 2.8.5.3. a summary of care provided and progress toward goals;
 - 2.8.5.4. community resources or referrals provided to the patient; and
 - 2.8.5.5. discharge medications.

Section 2.9. Delinquent Medical Records:

- 2.9.1. A medical record shall not be permanently filed until it is completed by the responsible physician or it is ordered to file by the committee responsible for the medical record function.
- 2.9.2. The patient's medical record shall be as complete as reasonably practical at the time of discharge, including progress notes, final diagnosis, and the clinical resume work sheet completed.
- 2.9.3. A reminder shall be placed on any chart deficient in the H&P during the next working day after which such deficiency occurs. If such H&P has not been written or dictated upon the expiration of 72 hours, a written report shall be sent to the committee responsible for the medical records function with a copy of such report to the physician responsible for the H&P and the practitioner's clinical privileges may be deemed to have been automatically relinquished in accordance with the Medical Staff Bylaws.
- 2.9.4. All medical records should be completed within fifteen (15) days after the date of discharge, or fifteen (15) days after essential reports have been received and placed into the record, whichever shall last occur. The Health Information Management Department shall determine those medical records that are incomplete after the time period specified above and promptly notify the practitioner of such incomplete medical records. If after such notice the medical records remain incomplete thirty (30) days post discharge, the practitioner's clinical privileges may be deemed to have been automatically relinquished in accordance with the Medical Staff Bylaws.

- 2.9.5 Provider Queries will be generated when additional documentation or clarification is needed for coding or quality.
- 2.9.5.1 All Provider Queries must be met with a response.
 - 2.9.5.2 Responses to Provider Queries must be provided in a timely fashion.
 - 2.9.5.3 Provider Queries will be included in the Medical Record completion requirements and considered during Deficiency/Delinquency and Relinquishment Processes.
- 2.9.6. Delinquent practitioners must coordinate coverage for their patients until such time as delinquent records are complete. Health Information Management (“HIM”) will notify Patient Registration, Scheduling, Surgery, Nursing Administration, and One Call shall be notified of all relinquishments and reinstatements.
- 2.9.7. Quarterly reports of such relinquishments shall be sent to the committee responsible for the medical record function for additional action by the Medical Executive Committee as appropriate.

ARTICLE 3

MEDICAL ORDERS

Section 3.1. General:

- 3.1.1. Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the Computerized Provider Order Entry (“CPOE”). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient’s EMR via the CPOE in accordance with Hospital policy.
- 3.1.2. All orders (including verbal/telephone orders) must be:
 - 3.1.2.1. dated and timed when documented or initiated. Outpatient orders are not required to be timed;
 - 3.1.2.2. authenticated by the ordering practitioner. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that are made in emergency situations or when the CPOE is unavailable and have been previously authenticated via written signatures or initials; and
 - 3.1.2.3. documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.
- 3.1.3. Orders for tests and therapies will be accepted only from:
 - 3.1.3.1. members of the Medical Staff;
 - 3.1.3.2. allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges; and
 - 3.1.3.3. other individuals not on the Medical Staff who have been granted permission to order services pursuant to Hospital policy.
- 3.1.4. The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.
- 3.1.5. Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated

time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

- 3.1.6. Allied Health Professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders issued by an allied health professional will be countersigned/authenticated by the supervising physician by the close of the medical record.
- 3.1.7. Resident physicians may issue orders only in accordance with the specific policies and procedures that have been duly adopted by the Graduate Medical Education Committee and the Board.

Section 3.2. Medication Orders:

All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

Section 3.3. Verbal Orders:

- 3.3.1. A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.
- 3.3.2. All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient. Any alerts prompted by the electronic system will be resolved by the physician while on the telephone.
- 3.3.3. For verbal orders, the complete order will be verified by having the person receiving the information record and “read-back” the complete order (RAV).
- 3.3.4. Authentication will take place by the ordering practitioner, or another practitioner who is responsible for the patient’s care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, and (ii) within 30 days after discharge if the order is documented using RAV. If the order was not documented using RAV, the order shall be signed, dated and timed within 48 hours.

- 3.3.5. The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:
- 3.3.5.1. a licensed practice nurse, a registered nurse, or an advance practice registered nurse (“APN”);
 - 3.3.5.2. a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
 - 3.3.5.3. a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;
 - 3.3.5.4. a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;
 - 3.3.5.5. a radiology or imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may transcribe a verbal order pertaining to tests and/or therapy treatments in their specific areas of expertise;
 - 3.3.5.6. an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;
 - 3.3.5.7. a speech therapist who may transcribe a verbal order pertaining to speech therapy; and
 - 3.3.5.8. a dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition.

Section 3.4. Standing Orders and Protocols:

- 3.4.1. For all standing orders and protocols that permit treatment to be initiated without a prior specific order from the attending physician, review and approval of the Medical Executive Committee and the Hospital’s nursing and pharmacy departments is required. Prior to approval, the Medical Executive Committee will confirm that the standing order or protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is an annual review of such orders and protocols. All standing orders and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.
- 3.4.2. If the use of a standing order or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient’s care in the Hospital and acting within his or her scope of practice.
- 3.4.3. When used, standing orders and protocols must be dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

3.4.4. The attending physician must also acknowledge and authenticate the initiation of each standing order or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.

ARTICLE 4

AUTOPSIES

- 4.1. Every member of the Medical Staff is expected to be interested in securing autopsies.
- 4.1.1. There should be consideration for performance of an autopsy under the following circumstances. The attending physician should use his discretion in obtaining autopsy permits. Autopsies are to be obtained only by the attending physician.
- 4.1.1.1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
- 4.1.1.2. Deaths in which the cause is not known with certainty on clinical grounds.
- 4.1.1.3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death and provide reassurance to them regarding the same.
- 4.1.1.4. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
- 4.1.1.5. Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction such as the following:
- persons dead on arrival at the Hospital;
 - deaths occurring in the Hospital within 24 hours of admission;
 - deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- 4.1.1.6. All obstetric deaths.
- 4.1.1.7. All neonatal and pediatric deaths.
- 4.1.1.8. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.
- 4.1.1.9. Deaths known or suspected to have resulted from environmental or occupational hazards.

- 4.1.2. No autopsy shall be performed without written consent of a relative or legally authorized agent.
- 4.1.3. All autopsies shall be performed by the Hospital pathologist or by a physician delegated this responsibility.
- 4.1.4. When an autopsy is performed, the provisional anatomic diagnosis should be reported in the medical record within three days and the complete protocol should be made a part of the record within 90 days. If such information is not documented timely, notification of the Practitioner and Chief Executive Officer for chart delinquency shall apply after 90 days.

ARTICLE 5

EMERGENCY CALL COVERAGE REQUIREMENTS

Section 5.1. General:

- 5.1.1. Medical Directors of the clinical departments of the Hospital will furnish the Hospital with monthly rosters of specialists on call each day.
 - 5.1.1.1. Emergency Room physicians have the right and duty to consult with members of the Medical Staff of the Hospital on call when examination and treatment may exceed the scope of the Emergency Room Physician's knowledge and experience.
- 5.1.2. In view of the "call system" evolved by practicing physicians, it shall be mandatory in the case of service patients both inpatients and outpatients, that a physician sign out only to another physician of the same department, as is determined by his staff privileges.
- 5.1.3. All patients presenting themselves to the Emergency Room of the Hospital will be seen by an appropriate practitioner.
 - 5.1.3.1. If a patient has a private physician and arrangements have not been made to meet his/her private physician at the Emergency Room, the Emergency Room Physician or his designee will promptly conduct a medical evaluation of the patient.
 - 5.1.3.2. If the patient has no private physician and does not desire one to be called, examination and treatment shall be rendered by the Emergency Room Physician.
 - 5.1.3.3. Patients will be referred in accordance with the policies of the Medical Staff.
- 5.1.4. Whenever a practitioner's admitting prerogatives and clinical privileges are relinquished, the Medical Director of the department to which the practitioner is assigned shall be notified by the Administrator or his designate of such action in order that alternative arrangements can be made to fulfill service call and other departmental obligations.

Section 5.2. Medical Screening Examinations:

- 5.2.1. Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

5.2.1.1. Emergency Department:

5.2.1.1.1. members of the Medical Staff with clinical privileges in Emergency Medicine;

5.2.1.1.2. other Active Staff members;

5.2.1.1.3. resident physicians; and

5.2.1.1.4. appropriately credentialed allied health professionals.

5.2.2. The results of the medical screening examination must be dictated within 48 hours of the conclusion of an Emergency Department visit.

ARTICLE 6

CONSULTATIONS

Section 6.1. Requesting Consultations:

- 6.1.1. The attending physician shall be responsible for requesting a consultation when indicated and for calling in a qualified consultant.
- 6.1.2. Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician shall make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for critical care consults, the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.
- 6.1.3. Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.
- 6.1.4. Where a consultation is required for a patient in accordance with this Article or is otherwise determined to be in the patient's best interest, the CMO, the President of the Medical Staff, or the appropriate department chief shall have the right to call in a consultant.

Section 6.2. Responding to Consultation Requests:

- 6.2.1. Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.
- 6.2.2. For non-critical care consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the attending physician and consultant shall agree on a specific time frame for the consultation to be performed.
- 6.2.3. The physician who is asked to provide the consultation may ask an allied health professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an allied health professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the allied health professional is sufficient.

- 6.2.4. Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the peer review process or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation:
- 6.2.4.1. the physician has a valid justification for his or her unavailability (e.g., out of town);
 - 6.2.4.2. the patient has previously been discharged from the practice of the physician;
 - 6.2.4.3. the physician has previously been dismissed by the patient;
 - 6.2.4.4. the patient indicates a preference for another consultant; or
 - 6.2.4.5. other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide a consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria listed above, then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the CMO, the President of the Medical Staff, or the appropriate clinical department chief can appoint an alternate consultant.

Section 6.3. Recommended and Required Consultations – General Patient Care Situations:

- 6.3.1. Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient is incompetent.
- 6.3.2. Consultations are required in all cases which, in the judgment of the attending physician:
 - 6.3.2.1. the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - 6.3.2.2. unusually complicated situations are present that may require specific skills of other practitioners;
 - 6.3.2.3. the patient exhibits severe symptoms of mental illness or psychosis such that the attending physician determines that consultation is necessary to provide appropriate care of the patient;
 - 6.3.2.4. the patient is not a good medical or surgical risk; or

- 6.3.2.5. except in an emergency situation, for curettages or other procedures by which a known normal intrauterine pregnancy may be interrupted.

ARTICLE 7

DEPARTMENTAL RULES AND REGULATIONS

- (a) Clinical departments may develop department-specific rules and regulations to the extent that they are consistent with all duly adopted Medical Staff and Hospital bylaws, rules and regulations, policies and procedures.
- (b) Departmental rules and regulations shall be forwarded to the Medical Executive Committee for review and recommendation to the Board for final action. All such departmental rules and regulations shall only be effective upon approval of the Board.
- (c) Duly adopted departmental rules and regulations shall be appended to these Medical Staff Rules and Regulations. To the extent any departmental rules and regulations are inconsistent with these Rules and Regulations and/or the Medical Staff Bylaws, they are of no force or effect.

ARTICLE 8

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article VII of the Medical Staff Bylaws.

ARTICLE 9

ADOPTION

These Medical Staff Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

September 23, 2008

October 23, 2012

August 28, 2015

June 12, 2017

Approved by the Board:

September 23, 2008

October 23, 2012

August 28, 2015

June 26, 2017



TITLE: PROCEDURES RELATING TO MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES	SEARCH WORD: Procedures relating to Medical Staff Membership and Clinical Privileges
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATE: 8/28/15, 10/29/2018

PROCEDURES RELATING TO MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

A. ORIGINAL APPLICATIONS FOR MEDICAL STAFF MEMBERSHIP, CLINICAL PRIVILEGES OR BOTH

1. SUBMISSION OF APPLICATION

a. Form of Application and Information Required

All applications for appointment to the Medical Staff or for granting of clinical privileges shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Medical Executive Committee and approved by the Administrator whose approval shall not be unreasonably withheld. The application shall require:

- i. For applicants seeking Medical Staff Membership, a request for appointment to a particular Staff Category.
- ii. A request for the specific clinical privileges desired by the applicant.
- iii. Information concerning the applicant’s professional qualifications including licensure, training, and documented experience in categories of treatment areas of procedures.
- iv. The names of at least three physician or other practitioner references who can provide adequate information on the applicant’s current professional competence and ethical character.
- v. Information as to whether the applicant’s professional license or medical staff appointment or clinical privileges at another hospital have ever been reduced, revoked, suspended, not renewed, or voluntarily relinquished during an inquiry or disciplinary proceeding, and if applications for staff appointment and/or privileges at other hospitals have been denied.

Information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, denied, relinquished, challenged, or not renewed at any other hospital or health care institution, and as to whether any of the following have ever been voluntarily or involuntarily relinquished, challenged, revoked, suspended, reduced, denied or not reviewed.

1. Membership/fellowship in local, state, or national professional organizations
 2. Specialty board certification
 3. License to practice any profession in any jurisdiction
 4. Drug Enforcement Administration number
- vi. A statement that the applicant has received and understands the Bylaws, Rules and Regulations and any other written policies of the Staff, which the said Bylaws, Rules and Regulations and written policies if he/she is granted Staff membership, clinical privileges or both and to be bound by the terms thereof in all matters relating to the consideration of his/her application, whether or not he/she is granted Staff membership, clinical privileges or both.
- vii. A statement that the applicant agrees to abide by the Hospital Bylaws, which the Administrator's office shall supply to each applicant upon application to the extent such bylaws are consistent with these bylaws.
- viii. A statement whereby the applicant acknowledges that he/she has granted to the fullest extent permitted by law the authorization, confidentiality, immunity and indemnification of those parties involved in credentialing and peer review activities.
- ix. A statement whereby the applicant agrees that if an adverse ruling is made with respect to his/her staff membership, clinical privileges or both, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to any formal legal action against the Staff, any Staff member, or the Hospital, arising out of or in connection with the application process, the applicant shall notify the Administrator of his/her intended action setting forth therein the basis for such action and the specifics to be charged or alleged.
- x. A statement of his/her willingness to appear for an interview in regard to his/her application.
- xi. A statement regarding health impairments, if any, affecting the applicant's ability in terms of skill, attitude or judgment to perform professional or Staff duties fully, hospitalizations or other institutionalization for significant health problems during the past five (5) year period; date of last physical examination with name and address of performing physician and significant findings; and
- xii. A statement whereby the applicant certifies that he/she maintains professional malpractice insurance coverage in at least such amount as may be required by applicable provisions of the Bylaws or other Hospital policies, and which specifies the amount of said coverage, and the name and address of the malpractice insurer. The application shall further require information

concerning any malpractice claims against the applicant, any amount paid by or on behalf of the applicant upon final judgment or settlement of such claim, the basis of the claim if such payment was made and any pending claims. The application shall contain a statement whereby the applicant agrees to notify the administrator promptly of any changes in said professional malpractice insurance, any claims against said professional malpractice insurance and any adverse final judgments or settlements in any professional liability action.

b. Effect of Application

By submitting the application, the applicant

- i. Authorizes the Staff and Hospital to contact other entities with which the applicant has been associated and others who may have information bearing on his/her licensure, competence, character, and ethical qualifications, including with out limitation the National Practitioner Data Bank as established by the Health Care Performance Improvement Act: The American Medical Association's Physician Master file and the Federation of State Medical Board's Physician Disciplinary Data Bank.
- ii. Agrees to attest to his/her physical, emotional or mental status.
- iii. Consents to the Staff and the Board inspecting all records and documents that may be material to an evaluation of his/her professional qualifications, current professional competence to carry out the clinical privileges he/she requests, and in the case of a physician applying for Staff membership, his/her moral and ethical qualifications for Staff membership.
- iv. Releases from any liability all individuals and organizations who provide information in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for Staff membership appointment, clinical privileges or both, including otherwise privileged or confidential information.
- v. Acknowledges that any actions or recommendations of any committee or the Board with respect to the Credentialing or Peer Review activities of the applicant are done so as a medical review committee can, and are part of the professional peer review process; and
- vi. Pledges to provide for continuous care for his/her patients if granted Staff membership.

c. Responsibility of Applicant

The applicant shall have the responsibility of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualification, and for resolving any doubts about such qualifications, and said application shall not be considered completed for purposes of processing until such satisfactory information is provided by the applicant and verified by the Administrator, acting as the designee of the Staff.

d. Completed Application

The completed application shall be submitted to the Administrator. The application shall not be considered complete until the Administrator, with the full cooperation of the applicant, has received necessary references and materials required to be submitted under this policy. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in the Bylaws. Any determination made by the Administrator that the application is complete shall not foreclose a subsequent decision to defer action on the application as described below.

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

e. Chief of Staff Procedure:

The Administrator shall transmit the complete application and all supporting materials to the Chief of Staff. In determining whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested, the Chief of Staff may use the expertise of any member, or an outside consultant, or ask the applicant to provide further information. Failure of an applicant to provide information within a reasonable time after being requested to do so shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

The Chief of Staff may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). The Chief of Staff may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

f. Medical Executive Committee Recommendation:

At its next regular meeting after receipt of the recommendation of the Chief of Staff, the MEC shall:

- (1) adopt the recommendation of the Chief of Staff, as its own; or
- (2) refer the matter back to the Chief of Staff for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
- (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Chief of Staff's recommendation.

If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board through the Chief of Staff.

If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC shall forward its recommendation to the Administrator, who shall promptly send special notice to the applicant. The Administrator shall then hold the application until after the applicant has completed or waived a hearing and appeal.

g. Board Action:

Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

- (1) appoint the applicant and grant clinical privileges as recommended; or
- (2) refer the matter back to the Chief of Staff or MEC or to another source inside or outside the Hospital for additional research or information; or
- (3) reject or modify the recommendation.

If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the Administrator shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

Any final decision by the Board to grant, deny, revise, or revoke appointment and/or clinical privileges is disseminated to appropriate individuals within the Hospital and, as required, reported to appropriate external entities.

2. QUALIFICATIONS

a. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or clinical privileges, the applicant must, as applicable:

- i. have a current, unrestricted license to practice in this state and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- ii. have a current, unrestricted DEA registration and state controlled substance license;
- iii. be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- iv. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- v. have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

- vi. have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
 - vii. have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
 - viii. have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;
 - ix. have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
 - x. have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those who apply for initial staff appointment on or after the date of adoption of this Policy.);
 - xi. be board certified in their primary area of practice at the Hospital. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for medical staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training (This requirement is applicable only to those who apply for initial staff appointment after the date of adoption of this Policy. All individuals appointed previously will be governed by the board certification requirements in effect at the time of their appointments.); and
 - xii. demonstrate recent clinical activity in their primary area of practice during at least two of the last four years.
- b. Waiver of Threshold Eligibility Criteria:
- i. Waivers of threshold eligibility criteria will not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment or clinical privileges will not be processed unless the Board has granted the requested waiver.
 - ii. A request for a waiver will only be considered if the applicant provides information sufficient to demonstrate that his/her qualifications are equivalent

to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.

- iii. The Chief of Staff may consider supporting documentation submitted by the applicant, any relevant information from third parties, and the best interests of the Hospital and the communities it serves. The Chief of Staff will forward its recommendation, including the basis for such, to the MEC.
- iv. The MEC will review the recommendation of the Chief of Staff and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
- v. The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

c. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

- i. relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- ii. adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- iii. good reputation and character;
- iv. ability to safely and competently perform the clinical privileges requested;
- v. ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- vi. recognition of the importance of, and willingness to support the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

B. REAPPOINTMENT

1. ELIGIBILITY FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have:

- a. completed all medical records;
- b. completed all continuing medical education requirements;
- c. satisfied all medical staff responsibilities, including payment of any dues, fines, and assessments;
- d. continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- e. paid any applicable reappointment processing fee; and
- f. had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization), before the application will be considered complete and processed further.

2. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section A.2.c of this Policy will be considered, as will the following additional factors relevant to the member's previous term:

- a. compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
- b. participation in medical staff duties, including committee assignments and emergency call;
- c. the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- d. any focused professional practice evaluations;
- e. verified complaints received from patients or staff; and
- f. other reasonable indicators of continuing qualifications.

3. REAPPOINTMENT APPLICATION

- a. Reappointment will be for a period of not more than two years.

- b. An application for reappointment will be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.
- c. Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges.
- d.
- e. The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- f. The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received. Completed applications will be processed
- g. If the Chief of Staff or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair shall notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made. Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

4. CONDITIONAL REAPPOINTMENTS

- a. Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any applicable conditions.
- b. A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- c. In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

TITLE: RULES AND REGULATIONS RELATING TO ADMINISTRATIVE FUNCTIONS		SEARCH WORD: Rules and Regulations Relating to Administrative Functions	
DEPARTMENT: MEDICAL STAFF			
PRESIDENT APPROVAL:		MEDICAL DIRECTOR APPROVAL:	
EFFECTIVE DATE:		REVISED DATE: 8/28/2015	

RULES AND REGULATIONS RELATING TO ADMINISTRATIVE FUNCTIONS

AND REGULATIONS:

- The Rules and Regulations of the medical staff must conform to the Bylaws of the medical staff, and must be approved by both the Governing Body and the medical staff at a general meeting.
- Suggested changes in Medical Staff Rules and Regulations may be initiated by individual staff members, the Chief of Staff and/or the Medical Staff Committee.
- Policies proposed by the standing committees of the medical staff when approved by the Governing Body will be binding on the members of the medical staff.
- In an emergency, the Chief of Staff is empowered to act on behalf of the medical staff.
- Failure of physicians to comply with the Medical Staff Rules and Regulations renders them subject to disciplinary action.

TITLE: ADVANCE DIRECTIVE	SEARCH WORD: Advanced Directive
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

ADVANCE DIRECTIVE

- An advance directive is a document that states choices about medical treatment or names someone authorized to make decisions about medical treatment if the person is unable to make these decisions or choices. The document is called an advance directive because it is signed in advance to let the physician and other healthcare providers know the person's wishes concerning medical treatment. An advance directive is essentially any document that states the patient's wishes regarding his/her healthcare choices, however not every document is legally binding. Many advance directives are state specific; therefore healthcare providers are responsible to know which advance directive is legally binding in the state where the patient is receiving treatment.
- The attending or referring practitioner may be required to identify a surrogate decision-maker for the patient, should that patient arrive in the hospital unaccompanied and without a legally binding advance directive.
- On admission, the hospital will ask the patient whether they have an advance directive or not. The hospital will provide the state approved brochure upon request.
- The patient or surrogate has the obligation to produce a copy or substance of the advance directive so that appropriate medical orders can be written and will coincide with the wishes of the patient and/or family, when possible.

DEFINITION OF ADVANCE DIRECTIVE:

An advance directive is an oral or written statement made by a competent patient which states his/her preferences regarding medical treatments, including, but not limited to, life-sustaining treatments or which designates a surrogate decision maker who will make decisions regarding medical care in the event the patient is unable to do so.



TITLE: ALLIED HEALTH PROFESSIONALS AND STUDENTS	SEARCH WORD: Allied Health Professionals and Students
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

ALLIED HEALTH PROFESSIONALS AND STUDENTS

- Prior to high-risk interventions, all patient histories and physical exams written by physician assistants or nurse practitioners shall be amended as necessary and countersigned by a licensed physician.
- All entries made in the medical record by all students shall be edited, amended as necessary, and countersigned by the appropriate supervisor.
- The medical record must document a member of the medical staff has seen the patient and concurs with the diagnosis and treatment plan. The medical staff member must also demonstrate his/her continued supervision of the resident, RNP, CNS, ESRN, CRNA or PA by appropriate documentation on the chart.
- The medical staff member responsible for the patient's care shall document supervision of care and treatment provided to patients by members of the house staff and allied health professionals in progress notes of the patient's medical record at least once a week for inpatients in acute care settings, or as frequently as is warranted by the patient's condition.



TITLE: AMBULATORY RECORDS	SEARCH WORD: Ambulatory Records
DEPARTMENT:	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

AMBULATORY RECORDS

- The ambulatory care medical record will be considered incomplete if by the patient's third visit a summary ("problem") list of known significant diagnoses, conditions, procedures, drug allergies and medications has not been initiated.

- The format will be consistent with the SOAP methodology:
 - S Subjective findings
 - O Objective findings
 - A Assessments
 - P Plan or Treatment/Management Plan



TITLE: ANCILLARY ASSESSMENTS	SEARCH WORD: Ancillary Assessments
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

ANCILLARY ASSESSMENTS

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- All patients admitted to the hospital shall have appropriate laboratory tests ordered by the attending practitioner or as per approved protocol.
- Laboratory, radiology, EKG, pathology and other essential reports must be incorporated into the medical record within 24 hours, as appropriate to the nature of the test.

NUTRITIONAL:

All patients, regardless of their nutritional status or need, receive a prescription or order for food or other nutrients. The food or other nutrients can range from nothing by mouth (NPO) to regular diets.

TITLE: BIOMEDICAL EQUIPMENT		SEARCH WORD: Biomedical Equipment	
DEPARTMENT:			
PRESIDENT APPROVAL:		MEDICAL DIRECTOR APPROVAL:	
EFFECTIVE DATE:		UPDATED: 8/28/15	

BIOMEDICAL EQUIPMENT

- The Biomedical Engineering Department must approve all electrically operated devices for use in the hospital. All equipment, including equipment being demonstrated by sales representatives, must be evaluated for safety, prior to use on any patients.

- Written policies and procedures shall be established for special precautions when the care of a patient requires the use of any type of electrically operated device. Written records are necessary for documenting all inspections performed on electrical and electronic systems and equipment. This includes documenting any action taken or recommended. Each Clinical Service Chief should maintain these documents in his/her service.



TITLE: CONFIDENTIALITY AND AVAILABILITY OF THE MEDICAL RECORD		SEARCH WORD: Confidentiality and Availability of the Medical Record	
DEPARTMENT: MEDICAL STAFF			
PRESIDENT APPROVAL:		MEDICAL DIRECTOR APPROVAL:	
EFFECTIVE DATE:		UPDATED: 8/28/15	

CONFIDENTIALITY AND AVAILABILITY OF THE MEDICAL RECORD

- The medical record, including x-ray films, is the property of the hospital. Release of the record, copies of the record or patient identifiable information contained in the record is within the discretion of the hospital except as otherwise controlled by state and federal law.
- Records may be removed from the hospital's jurisdiction only in accordance with a court order, subpoena or statute.
- Records of psychiatric and/or substance abuse patients shall be protected from disclosure in accordance with the “State” Welfare and Institution code and federal regulations governing the confidentiality of substance abuse patient records.
- As a matter of expedience, and in the patient's interest, medical record information, confined to that which relates to the hospital or medical care of the patient, may be released to interested persons on a need to know basis without the patient's specific, authorization unless requested not to do so by the patient, next of kin or the provider of healthcare following the guidelines of the most current revision of the “State” Association of Hospitals and applicable federal regulations.
- In extraordinary cases, revelation of the fact of which might be considered highly prejudicial to the patient's reputation, consent of the attending physician and special written consent of the patient or his legal representative should first be obtained. Records of discharged patients shall be sent to the Medical Records Department no later than the day after discharge, unless the attending physician specifically requests that they be held at the nursing station. Such records will be held for no longer than 36 hours after the patient's discharge.
- Incomplete medical records may not leave the Medical Records Department except for continuing patient care of readmitted patients, and then must be returned within 72 hours.
- Records needed for studies or research not involving human subjects should be requested in advance by application in the Health Information Management Department. Proposed projects shall be reviewed by the Medical Record Committee who shall make recommendations to the Medical Staff Committee before records can be studied. Subject to the review and approval of the Medical Staff Committee, through the recommendations from the Medical Record Committee, former members of

the medical staff shall be permitted free access to information from the medical records of their own patients, covering all periods during which they attended such patients in the hospital.

- In cases of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.
- Unauthorized removal of charts from the hospital premises is grounds for suspension of a practitioner for a period to be determined by the Medical Staff Committee of the Medical Staff. Premises of the hospital are defined as any area of the hospital in which inpatients undergo diagnostic or therapeutic interventions, and those areas, with the exception of private physician's offices, where outpatient procedures are conducted.



TITLE: CORRECTIVE ACTION	SEARCH WORD: Corrective Action
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

CORRECTIVE ACTION

AND CONDUCT

1. Conduct Requiring

Activities or professional conduct of any practitioner detrimental to patient safety or to the delivery of quality patient care, or conduct lower than the accepted standards or aims of the Staff or behavior disruptive to the Hospital operation, or conduct in violation of or contrary to these Bylaws, the Rules and Regulations of the Staff, or the Rules and Regulations of the Hospital to the extent consistent with these Bylaws, may be deemed appropriate for corrective action.

2. Initiation

Corrective action can be initiated by any officer of the Staff, the Chair of any clinical area, the Chair of any standing committee, the Administrator, or the Board. All requests for corrective action shall be submitted to the Medical Executive Committee in writing and supported by reference to the activities or conduct constituting grounds for the request. A copy of the request and notice of the practitioner's right to appear pursuant to Paragraph (3) (b) below shall immediately be sent to the practitioner by the Medical Executive Committee by certified mail return receipt requested or by personal service. The Chair of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith.

3. Medical Executive Committee Action

a. Time

Within thirty (30) days following receipt of a request for corrective action, unless affected practitioner agrees to an extension of time, the Medical Executive Committee shall take action upon the requires or permit an appearance by the affected practitioner.

b. Appearance by Member

If the correct action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Staff, the affected practitioner shall be afforded an opportunity to make an appearance before the Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, but shall be preliminary and investigative in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

c. Recommendation

Within ten (10) calendar days following an appearance by the practitioner the Medical Executive Committee shall take action with respect to the matter. A written record of action on the request for corrective action shall be made by the Medical Executive Committee and kept on file at the Hospital. The Medical Executive Committee shall promptly notify the Administrator of its action made in regard to a request for corrective action.

d. Permitted Action

On a request for corrective action, the Medical Executive Committee of the Staff may take one of the following actions: A warning; letter of admonition; letter of reprimand; impositions of terms of probation or a requirement for consultation or continuing medical education; recommendation for reduction, suspension or revocation of clinical privileges; recommendation for alteration of already imposed restrictions; recommendation for suspension or revocation of Staff membership; absolution of the practitioner; or any alternative to the above-named to be deemed appropriate by the Medical Executive Committee. Action so taken may form the basis of future actions.

4. Action By Administrator

If any action or recommendation of the Medical Executive Committee is adverse to the practitioner, the Administrator shall, within ten (10) calendar days after the Medical Executive Committee's decision, notify the affected practitioner in writing by registered mail, certified mail, or by personal service, notifying him/her of the action and recommendations, or either of them taken by the Medical Executive Committee and the specific reasons and finding upon which said decision or recommendation was based. If the action or recommendation, if final would require a report to the National Practitioner Data Bank and the appropriate state licensing agency, or either of them, the notice shall include the notice of the fact and the text of such proposed reports. The notice shall further advise the practitioner of his/her rights to a hearing; specify that he/she shall have thirty (30) days following the date of his/her receipt of the notice within which to request a hearing or appellate review; state that the failure to request a hearing or appellate review within the specified time period shall constitute a waiver of his/her right to the same; state that upon receipt of his/her request he/she will be notified of the date, time, and place for the hearing or appellate review and the grounds upon which the adverse action is based; advise him/her of his/her right to review the hearing record and report, if any, and to submit a written statement on his/her right to legal counsel and assistance at the hearing and appellate review. In the event that the practitioner is entitled to, and requests such a hearing or appellate review, the procedures set forth in Policy # 1027 shall be followed.

CONFIDENTIALITY

All proceedings involving practitioners must be held in the strictest confidence. Any breach of this confidentiality by committee members will be considered grounds itself for disciplinary action. Practitioners are urged not to inquire into ongoing proceedings. The Board will also cause the Administration to maintain such portions of the proceedings as may come to its attention in strictest confidence.

SUMMARY SUSPENSION

1. Circumstances

The Chief of Staff, the Medical Executive Committee, the Administrator or the Board, in consultations with the Chair or Vice Chair of the respective area, shall constitute and ad hoc committee for the limited purposes of this Section and shall have the right, whenever action must be taken immediately to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, to summarily suspend all or any portion of the clinical privileges of a practitioner, effective immediately upon impositions. Where summary suspension is imposed by a person or persons other than the Chief of Staff, that person or persons should immediately transmit notice of the suspension to the Chief of Staff.

2. Notice

Upon receipt of the notice of the summary suspension of a practitioner, the Chief of Staff shall promptly transmit notice of the suspension to the Administrator, who shall promptly notify the affected practitioner in writing of the suspension and the grounds therefore and notice of his/her right to a meeting with the Medical Executive Committee pursuant to Paragraph (3) below. This notice shall be delivered to the practitioner in person if practical; if not, then by certified or registered mail.

3. Investigative Meeting

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request, at any time within ten (10) calendar days following receipt of notice such summary suspension, that the Medical Executive Committee hold an investigative meeting not less than three (3) nor more than seven (7) calendar days after the Chair of the Medical Executive Committee receives a written request for such a meeting. The purpose of this meeting shall be to determine whether an actual risk of immediate injury or damage to the health or safety any patient actually exists so as to support the imposition of summary suspension. The Chief of Staff shall set the date for the meeting in consultation with the affected practitioner. The affected practitioner may be present, but neither the practitioner nor the Staff may be represented by legal counsel at this investigative meeting.

a. Recommendations

As a result of the meeting, the Medical Executive Committee may recommend modification continuance or termination of the terms of the summary suspension, as well as recommending alternative corrective actions.

b. Notice

Notice of an adverse recommendation shall be given pursuant to Section Titled Procedures And Conduct (4) above.

c. Hearing or Appellate Review

If the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall in accordance with Policy # 1027, be entitled to request a hearing or appellate review, but the terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Board. Where the affected practitioner request a hearing or appellate review, the procedures sent forth in Fair Hearing Plan And Appellate Review shall be followed.

4. Alternative Patient Care

Immediately upon the imposition of a summary suspension, the Chief of Staff shall have authority to provide for alternative medical coverage for the patient(s) of the suspended practitioner. The wishes of the patient(s) shall be considered in the selection of such alternative practitioner.

5. Reports of Summary Suspension

- a. Written fifteen (15) days following any adverse professional review action involving a summary suspension for longer than thirty (30) days, a report shall be made to the Composite State Board of Medical Examiners or other appropriate state licensing board; and
- b. Within twenty (20) days following any final action involving a summary suspension; a report shall be made to the Composite State Board of Medical Examiners or other appropriate state licensing board.

AUTOMATIC SUSPENSION

1. State Board Action

Action by the Composite State Board of Medical Examiners or other appropriate licensing board revoking or suspending a practitioner's license shall automatically suspend the practitioner's Staff membership and clinical privileges. Action by the appropriate state licensing board revoking or suspending the license of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges. Such suspension of Staff membership and clinical privileges shall continue throughout the period during which the practitioner's license is revoked or suspended. In the absence of any corrective action, which has adversely affected the practitioner's staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's license by the Composite State Board of Medical Examiners or other appropriate state licensing board.

2. Drug Enforcement Administration Action

Action by the Drug Enforcement Administration (including voluntary relinquishment by the practitioner) revoking or suspending a practitioner's controlled substances registration shall automatically suspend the staff membership and clinical privileges to the extent necessary to be consistent with the action taken by the Drug Enforcement Administration. Action by the Drug Enforcement Administration revoking or suspending the controlled substances registration of a limited license professional exercising clinical privileges shall automatically suspend the limited license professional's clinical privileges to the extent consistent with the action taken by the Drug Enforcement Administration. In the absence of any corrective action, which has adversely affected the practitioner's staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner's registration by the Drug Enforcement Administration.

3. Medical Records – Staff Generally

A staff member may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner;

- a. A temporary suspension in the form of withdrawal of admitting privileges (hereinafter called "no bed status"), effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7) calendar days after the mailing by registered mail, certified mail, or by personal service to the affected Staff members, at his/her current office address supplied to him/her to the Hospital, of a written notice from the Chief of Staff of the Staff member's delinquency in completing his/her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During this seven (7) day period, the affected Staff member may explain any extenuating circumstances to the Chief of Staff who, in his/her discretion, may extend the period before the temporary suspension shall begin.
- b. Remaining on "no bed status" in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve-month period shall be grounds for immediate corrective action pursuant to Section Procedures and Conduct of this Corrective Action Article.

4. Medical Records – Consulting Staff and Limited License Professionals Exercising Clinical Privileges

A Consulting Staff member or limited license professional may have automatic suspension imposed for failure to complete medical records in accordance with Staff Rules and Regulations and these Bylaws, in the following manner;

- a. A temporary suspension in the form of a withdrawal of all a Consulting Staff member's consulting privileges and all of a limited license professional's clinical privileges (hereinafter referred to as "no consulting status"), except as to those patients to which the affected practitioner is providing direct patient care services or is acting as a consultant at the time of the suspension, effective until medical records are completed, shall be imposed following the recommendation of such suspension to the Medical Executive Committee by the Medical Records Committee. Such suspension shall be imposed automatically beginning seven (7)

calendar days after the mailing by registered mail, certified mail, or by personal service to the affected practitioner, at his/her current office address supplied by him/her to the Hospital, or a written notice from the Chief of Staff of the practitioner's delinquency in completing his/her medical records, with the Chief of Staff also sending a copy of said notice to the Medical Records Committee. During the seven (7) calendar day period, the affected practitioner may explain any extenuating circumstances to the Chief of Staff who in his discretion, may extend the period before the temporary suspension shall begin.

- b. Remaining on "no consulting status" in excess of thirty (30) days consecutively or forty-five (45) days total in any twelve month period shall be grounds for immediate corrective action pursuant to Section Procedures and Conduct of this Corrective Action Section.

5. Notice

The Chief of Staff shall promptly transmit notice of any suspension based on failure to complete medical records as described in Paragraph (3) and (4) above to the Administrator, who shall promptly notify the affected practitioner in writing of the suspension and the grounds therefore and notice of his/her rights, if any, under Article XII in the form prescribed by Section A (4) above. This notice shall be delivered to the practitioner in person, if practical; if not then by certified or registered mail. The Administrator shall likewise transmit notice of any suspension under Paragraphs (1) or (2) above.

6. Enforcement

It shall be the duty of the Chief of Staff and the Medical Executive Committee to cooperate with the Administrator in enforcing all automatic suspensions.

TITLE: CRITERIA FOR NEW PRIVILEGES AND TEMPORARY PRIVILEGES	SEARCH WORD: Criteria for New Privileges and Temporary Privileges
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

CRITERIA FOR NEW PRIVILEGES AND TEMPORARY PRIVILEGES

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Each medical staff section may, as appropriate, recommend more particular criteria for delineation of privileges within its specialties. These criteria shall be applicable to new applicants and when appropriate, current members of the staff as specified by the section, after approval by the Medical Staff Committee and Governing Body.

TEMPORARY STAFF PRIVILEGES:

Eligibility to Request Temporary Clinical Privileges

- Non-applicants. Temporary privileges may be granted to non-applicant by the CEO, upon recommendation of the Chief of Staff of the Medical Staff, when there is an important patient care, treatment, or service need. The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure, current competence, and current professional liability coverage acceptable to the hospital which may be accomplished through telephone calls. These temporary privileges may be granted for a maximum of thirty (30) days and may be renewed if necessary for additional thirty (30) day periods but the total may not exceed 120 days.
- Pending application. Temporary privileges may also be granted by the CEO, upon recommendation of the Chief of Staff of the Medical Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Staff Committee and Board, following a favorable recommendation of the Credentials Committee. Prior to temporary privileges being granted in this situation, the credentialing process must be complete including primary source verification of current licensure, relevant training or experience, current competency, ability to perform the privileges requested, current professional liability coverage, compliance with privileges criteria, current DEA, consideration of information from the National Practitioner Data Bank and from the medical attestation completed by the applicant and their attending physician, and signed acknowledgement of current Bylaws and Rules & Regulations. These temporary privileges may be granted for a maximum of thirty (30) days and may be renewed if necessary for additional thirty (30) day periods but the total may not exceed 120 days.

- Locum Tenens. The CEO may grant temporary privileges to an individual serving as a locum tenens for a member of the Medical Staff. This shall be done in the same manner and upon the same conditions as set forth in the “non-applicants” section paragraph under the Temporary Staff Privileges section.



TITLE: DELINQUENT MEDICAL RECORDS	SEARCH WORD: Delinquent Medical Records
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

DELINQUENT MEDICAL RECORDS

POLICY:

It is the policy of the Medical Records Department to notify a practitioner of suspension when he/she has delinquent medical records.

PROCEDURE:

Physicians will be notified on a weekly basis of their number of incomplete medical records through a letter until the medical records are complete or the physician is on suspension.

All deficiencies are noted, by responsible physician, on the medical record deficiency computer system. Deficient records are then placed in the Doctor's Lounge.

Should the Medical Record Department not receive a physician response to complete his/her medical records within twenty-eight (28) days of the first notice, the physician will be notified by a second reminder letter.

Should the medical record(s) remain incomplete on the 30th day after patient discharge, the Medical Records Department will notify the physician, via certified mail, that his/her admitting, consultative and surgical privileges have been suspended until his/her medical records have been completed. The Medical Records Department also submits his/her name to administration, the Medical Executive Board and other departments.

A copy of all suspension letters mailed are placed in the physician's peer review file housed in the Medical Staff Office.

The hospital departments are notified, by the Medical Records Department when the suspension of privileges has been lifted.

If a physician is on suspension for a total of 30 cumulative days in the fiscal year, his/her name shall be submitted to the Medical Executive Committee. The committee shall then submit his/her name to the State Medical Board.

Surgeons are notified by the Transcription Clerk if an operative report has not been received within 24 hours following surgery.

Any patient remaining in the hospital more than 24 hours shall require a dictated discharge summary.

**DELINQUENT MEDICAL RECORDS
LETTER**

St. Mary's Good Samaritan Hospital
1201 Siloam Road
Greensboro, Georgia 30642

Date: _____

_____, MD

Dear Dr. _____,

Recently, a patient was discharged from our facility and his/her chart contains some documentation deficiencies belonging to you. Our hospital policy is that a medical record must be completed within 30 days of discharge.

At the present time you have ____ incomplete charts.

Our department hours are Monday through Friday, 8 AM to 5 PM. After hours, the Medical Records Department Director will be available by phone. Please call prior to visiting us so we can have your charts ready for your completion, (706) 453-5036.

Thank you in advance for your kind cooperation.

Sincerely,

Dave Ringer, MD
Chief of Staff

PHYSICIAN'S NOTICE OF DELINQUENT CHARTS

First Letter Sent: _____ Reminder Letter Sent: _____ Phone Call: _____
 Who Called: _____ Suspension Letter Sent: _____ (certified)

Physician's Name	ID	First Letter	Reminder Letter	Phone Call Name/Message	Suspension Letter	No.	Alternative

**NOTICE OF UPCOMING SUSPENSION
FOR INCOMPLETE MEDICAL RECORDS
LETTER**

St. Mary's Good Samaritan Hospital
1201 Siloam Road
Greensboro, Georgia 30642

Date: _____

_____, MD

Dear Dr. _____,

Approximately one week ago, you received a letter from our hospital regarding deficient medical records. As of this date, we have not had a response to our request for completion of your charts.

In accordance with our medical staff bylaws, your medical staff privileges may be suspended as of _____.

This includes suspension of all admitting, consultative and operative procedures.

Our department hours are Monday through Friday, 8 AM to 5 PM. After hours, the Medical Records Department Director will be available by phone.

Please call prior to visiting us so we can have your charts ready for your completion, (706) 453-5036.

Thank you in advance for your kind cooperation.

Sincerely,

Jeannette Rivers
Medical Records Department Manager

MEDICAL STAFF SUSPENSION LIST

MEDICAL RECORDS DEPARTMENT

As of this date _____, the following physicians/providers are hereby suspended for Admissions, Consultations and/or Emergencies. Please contact their alternate coverage.

Name	Alternate	No. Charts

_____ Medical Records Department Director

Approved: _____

President

Chief of Staff

- D = Dictation
- S = Signature

cc: Administration
Admitting Department
Business Office Manager
Emergency Department
Medical Staff File
Nursing
Transcription
Utilization Management

PHYSICIANS SUSPENSION LOG

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Physician Name	Date of Suspension	Date Suspension Removed	Total # of Days of Suspension	Comments

**PHONE LOG
PHYSICIANS OFF SUSPENSION**

Physician	Date Off	Time Called	Department	Person Notified
			Admitting	
			ED	
			Admin	
			Med Staff	
			Nursing	
			PI	
			Surgery	
			Nurses' Station	



TITLE: DEPARTMENT OF PATHOLOGY	SEARCH WORD: Pathology
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

DEPARTMENT OF PATHOLOGY

CLINICAL LABORATORY:

- This department shall operate under the direction of the Chairperson of the Department of Pathology. In the absence of the director, one of the associate pathologists shall be designated to act as director according to the provisions in the Bylaws of the Medical Staff. On occasion, a pathologist other than the associate pathologist may do work in the department if temporary privileges have been granted.

NEW ADMISSIONS:

- *Physicians admitting patients for surgery must give orders for laboratory work prior to surgery, (please refer to other sections of the Medical Staff Rules and Regulations for pre-procedure testing requirements). The results of these orders must be available before the patient can go to surgery. Patients may be sent to the Clinical Laboratory for preadmission testing.*
- When additional laboratory tests are requested upon patient admission, the Clinical Laboratory or Admitting Departments should be notified as soon as possible so that the patient will not be inconvenienced by multiple venipunctures.

ORDERS:

All orders for laboratory tests on inpatients must be written on the chart. STAT orders may be telephoned to the Clinical Laboratory, but must be followed by written orders. All orders should be communicated to the Clinical Laboratory via the order entry computer system. Manual requisitions may be used for patients not entered into the computer system, for tests that do not have computer codes, and when the system is not in operation. Orders to cross-match additional blood for transfusions to patients already in surgery will be accepted by telephone but should also be noted on the doctor's order sheet either by the anesthesiologist or by the surgeon when the surgical procedure is completed.

BLOOD BANK DONOR ROOM:

- As soon as possible after patient admission, and 24 hours or more before surgery, orders for transfusions for surgical patients should be sent to the Clinical Laboratory. All requests for transfusions should specify the number of units of blood required and the time and date the blood will be administered.
- Non-emergent transfusions should be ordered for transfusion during normal working hours. Orders for special blood components should be sent to the Blood Bank as early in the day as possible.
- Only the amount of blood that will be given in a 24-hour period should be ordered for cross-matching at one time. Patients receiving daily transfusions should be cross-matched each day. Exceptions may be made for patients who are bleeding or otherwise critical and require several units of cross-matched blood on hand during the emergency. The Blood Bank should be notified as soon as the emergency has passed.
- Blood, which is cross-matched but not transfused, will be held in the Blood Bank for 24 hours after time of intended transfusion. It will be automatically returned to the Blood Bank unless otherwise requested.
- The attending physician should encourage the patient's family and friends to replace the blood, unit for unit, at the Red Cross or Hospital Blood Bank. Appointments or other inquiries concerning blood donations should be directed to the Blood Bank during normal business hours.

BACTERIOLOGY AND URINALYSIS:

Specimens for bacteriological examination should be collected as early as possible and sent immediately to the Clinical Laboratory for proper handling. The first morning specimen is the best for urinalysis. Samples must include two patient identifiers (Name, DOB, MRN). A source is required for all microbiology samples. (i.e. wound, left arm)

OUTPATIENTS:

- *Outpatients may be sent to the Clinical Laboratory at any time during the regular daytime hours for routine studies. A written order should accompany the patient. The regular hours for outpatients are 7 AM to 5 PM, Monday through Friday.*
- A report of all suspected transfusion related disease or complications are to be reported to the Blood Bank in writing, including AIDS, hepatitis CMV infections; delayed transfusion reaction symptoms and all cases of unexplained acute liver dysfunction occurring two (2) weeks to six (6) months after blood component(s) transfusion. Written notification should be initiated as soon as possible on any patient transfused at St. Mary's Good Samaritan so that appropriate follow-up testing can be conducted to document the progress of the disease process. This information is also needed to follow up on blood donors who may need medical treatment and to provide needed epidemiological data.

DIRECTED DONORS:

- *All directed donor units collected at other facilities are to be received pre-paid for all processing fees.*
- All directed donor units will be held for designee until expiration date or an approved medical necessity as agreed upon by the pathologist and attending physician.
- Directed donor units must be group specific to be transfused.
- All directed donor units will be billed to the designee upon receipt by the Hospital Blood Bank for handling fees regardless of whether they are used by the designee.
- All directed donor units must be accompanied by a physician's order, i.e., including patient name, blood type, date of surgery, number and type of blood components needed.
- Out of state directed donor components will not be accepted for transfusion at the Hospital Blood Bank.
- All units eligible for transfusion must be cross-match compatible.
- All recipients (designees) must have a record available to the Hospital Blood Bank that includes ABO group, Rh type and antibody screen results.
- A current copy of the Biologics License will be requested with all directed donor units from outside institutions.



TITLE: DEPARTMENT OF RADIOLOGY	SEARCH WORD: Radiology
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

DEPARTMENT OF RADIOLOGY

Good Samaritan Hospital and its Radiology staff shall maintain radiologic facilities and services adequate to meet the needs of the patient as defined by the medical staff.

QUALIFICATIONS FOR MEMBERSHIP - DEPARTMENT OF RADIOLOGY:

- *Must be a member of the medical staff, having applied and received appointment in the same manner as all other members of the medical staff.*
- Shall be certified by the American Board of Radiology, or be eligible for certification by that Board or have training and skills which make him/her acceptable as a radiologic consultant.
- A radiologist may admit patients for the performance of those procedures for which the radiologist has been granted privileges. When appropriate, the radiologist shall obtain consult from other specialty or subspecialty in other departments of the medical staff.

DUTIES AND RESPONSIBILITIES:

Each member of the department shall be expected to help perform, without composition, the general services and teachings duties of the department. These duties and responsibilities shall be outlined and assigned by the director of the department.

CATEGORIES OF THE RADIOLOGICAL STAFF:

Appointment to the medical staff with privileges in Radiology shall be in the same category as are provided for the staff in general, and the privileges and responsibilities of this staff appointment shall be in accordance with the Rules and Regulations of the Medical Staff.

DIRECTOR OF DEPARTMENT OF RADIOLOGY:

- The Radiology Department operates under the direction of the Chairperson of the Department.
- The Director shall be appointed in the manner outlined in the Medical Staff Constitution and Bylaws.

- In the absence of the Director, the Vice-Chairperson shall be designated to act as Director.
- Duties and Responsibilities of the Director:
 - He/She shall assume the responsibility for professional direction of the department under the Constitution and Bylaws of the Medical Staff of Saint Joseph's at East Georgia, and for the administrative direction in cooperation with the Hospital Chief Executive Officer.
 - He/She shall assist the medical staff and administration in every way possible to achieve a high level of patient care with efficiency and economy being taken into account and will assist the hospital administration in maintaining the Radiology Department according to the needs of the patients, the medical staff and the requirements of accrediting bodies.
 - He/She shall be responsible for the protection of personnel and patients against radiation hazards and the maintenance of proper safety precautions as required in the Standards of the Joint Commission on Accreditation of Hospitals as well as to assist in meeting other requirements for accreditation of the Department of Radiology as may be imposed by law.

MEETINGS:

- *Department meetings will be held monthly for the proper functioning of the department.*
- Only active members shall have the privileges of voting on departmental matters.

POLICIES AND PROCEDURES:

- *There shall be written policies and procedures governing radiologic administrative routines and services and radiation safety practices.*
- These procedures and policies are developed in cooperation with the medical staff, Nursing Services and other departments or services as necessary.
- It is the policy of this Hospital that all radiological studies made in the hospital have a written consultation and report made by a radiologist of the medical staff of the Department of Radiology, or by a qualified radiologist to whom temporary privileges have been extended.

FLUOROSCOPY GUIDED PERCUTANEOUS GASTROSTOMY:

- Qualifications:
 - *Any radiologist who wishes to perform the procedure and has experience in other drainage tube placement procedures (i.e., renal, biliary or abscess) may be granted this privilege, upon approval of the appropriate committees.*

Indications:

- When a patient is unable to ingest and long term enteral feeding is in the best interest of the patient.
- *Reflux*
- Technique:
 - This procedure may be performed on inpatients or outpatients in the Short Stay Unit. One (1) mg of Glucagon is given intravenously or intramuscularly to paralyze the stomach. The stomach is inflated with gas via a gastric tube. The body of the stomach is punctured avoiding the liver and the intestines. The track is dilated over a guidewire under fluoroscopic guidance and a 10 - 14 French self-retaining catheter is introduced. After verifying appropriate intragastric position, the catheter is connected to external drainage for 24 hours. After this period, feeding can begin.
 - Modification - The jejunum can be catheterized through the gastrostomy tract (i.e., in severe gastroesophageal reflux or in gastric outlet obstruction).
- Potential Complications:
 - Major complications have not been reported. However, peritonitis or abscess formation are potential complications.
- Contraindications:
 - Peritoneal fluid or tumor
 - Gastrointestinal obstruction
 - Gastric varices

(Difficulties: Access problems due to interposed liver, colon or prior surgery. Track dilation problems due to surgery or obesity.)



TITLE: DISPUTE RESOLUTION	SEARCH WORD: Dispute Resolution
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

DISPUTE RESOLUTION

APPLICABILITY OF ARTICLE

This article shall apply where the Staff and the Board or Administration are unable to agree on issues of mutual interest and concern, including, but not limited to:

1. Staff Membership and Clinical Privileges decisions.
2. Cost containment decisions.
3. Utilization review decisions.

The AMA supports the following principles that may assist in dispute resolution:

- (1) Hospital should establish a committee consisting of an equal number of board or trustees/directors and medical staff representatives, such as a joint conference committee, to address conflicts and attempt to resolve them as they arise. An outside facilitator or mediator might used to frame the issues objectively and impartially and identify the reasons communication between the hospitals governing board or management and the organized medical staff were not open or effective.
- (2) County and state medical societies that have not done so are encouraged to meet with their county and state hospital association or council counterparts to consider the feasibility of establishing a service that could be made available at the request of the Chair of the hospital governing board and the chief of the medical staff to assist in resolving any dispute between the two that could not be resolved within the institution. The representatives of each could serve as fact-find body and make recommendations on how the dispute or impasse might be resolved without the need to resort to litigation or generate adverse publicity for the parties.
- (3) Any mechanism or services available to assist individual governing board and management to resolve disputes with the hospital medical staff should be publicized

and widely disseminated. If the service involves identification of experienced facilitators or mediators, their availability should also be publicized.

- (4) Any mechanism or service made available for hospital resolution at the county or state level must have the capability of having individuals who can engage in fact-find at the particular hospital in which the dispute arose. The county/state association with appropriate input from the AMA, when requested, makes a decision on the type of assistance that is appropriate for that particular hospital dispute based on existing policies.
- (5) The use of alternative dispute resolution mechanisms available at the local level to resolve hospital governing board and management and hospital medical staff disputes should be encouraged and fostered in programs and publications of the AMA. AMA Policy Compendium (1990 Ed.) §47.008.

See, e.g. California Medical Association and California Association of Hospitals and Health Systems, Program for Resolving Conflict (January, 1992) designed to promote informal, voluntary, private and participative resolution of such conflicts.

Submission of Staff membership or clinical privileges dispute resolution procedure outlined in Dispute Resolution Article may result in a technical violation of the 90 day time limit contained in O.C.G.A § 31-7-7, if applicable. The securing of a written waiver from the affected applicant may be in order.

- (4) Employee performance; and
- (5) Quality of Hospital services

By adopting or approving these Bylaws, the Staff and the Board are deemed to agree to follow the procedures set forth in this Article in an attempt to resolve disputed matters prior to initiating any court action.

A. **MEDICAL EXECUTIVE COMMITTEE OR BOARD ACTION**

Whenever disagreement exists as to any of the issues described in Section A above, either the Medical Executive Committee or the Board shall be entitled to refer the matter to the Joint Conference Committee for discussion and interaction. Such referral shall be accomplished by the delivery of written matter to the Chair of the Joint Conference Committee and to the Chief of Staff (in the event the Board is the referring party) or the Chair of the Board (in the event the Medical Executive Committee is the referring party).

B. **JOINT CONFERENCE COMMITTEE ACTION**

1. Initial Effort to Resolve Dispute

Upon the referral of any matters to the Joint Conference Committee, the Committee shall meet once each week for a period of three (3) weeks and shall make a good faith effort to resolve the dispute

2. Mediation

In the event that the Joint Conference Committee is unable to reach a resolution of the dispute during its initial three-week effort, the Staff and the Board or Administrator shall each designate a representative to enter into mediation. In addition, the members of the Joint Conference Committee shall choose a qualified, neutral mediator, and the mediator shall meet with the representatives in order to assist in developing options and formulating alternatives for resolving the issue. The representatives may also meet, without the mediator, over the course of a three (3) week period in an effort to reach a resolution of the dispute, which is agreeable to each side. The mediation process shall be conducted promptly and in good faith, over a period not to exceed three (3) weeks, unless and extension of such time period is agreed to in writing by a majority of the Board representatives and a majority of the Staff representatives on the Joint Conference Committee. If the mediation process results in a proposed resolution acceptable to the Joint Conference Committee, the proposed resolution shall be reduced to writing by the Joint Conference Committee, and if the matter in controversy does not arise out of any alleged breach by any party of any contractual relationship existing between the Board and the Staff, or any individual member thereof, then the matter in controversy shall be submitted to the Board, in which case the action of the Board shall be final.

3. Arbitration

In the event the issue in dispute arises out of any alleged breach of any part of any contractual relationship existing between the Board and the Staff, or any individual member thereof, and in the event that the mediation process fails to resolve the disputed issue, the matter in controversy shall be submitted to arbitration pursuant to the provisions of the Georgia Arbitration Code (O.C.G.A. §9-9-1, et seq.) as the same may be amended from time to time. Arbitration shall be conducted by not more than three (3) arbitrators, at least one of whom shall be an attorney-at-law, and all of whom shall be experienced in dealing with hospital/medical staff issues. Upon application for arbitration by either the Board or the Staff, the Joint Conference Committee shall be given a reasonable opportunity to agree, by majority vote of the Board representatives and a majority vote of the Staff representatives on the Joint Conference Committee, on the arbitration panel; but in the event no agreement shall be reached as to the arbitration panel, the provisions of the Georgia Arbitration Code shall be given effect.

TITLE: DO NOT RESUSCITATE ORDERS	SEARCH WORD: Do Not Resuscitate Orders
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

DO NOT RESUSCITATE ORDERS

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The purpose of cardiopulmonary resuscitation is prevention of sudden unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or following prolonged cardiac arrest. Resuscitation in these circumstances may represent a positive violation of an individuals' right to choose not to have disproportionate means used to prolong the process of dying.

POLICY:

- The policy of Good Samaritan Hospital has been, and will remain, that all patients are resuscitated unless an order not to resuscitate or “no code” order, has been written in the patient's chart. It is because of this basic policy of the hospital that physicians must decide which patients are not to be resuscitated. The decision not to perform cardiopulmonary resuscitation has no implication for any other treatment decision. Any other form of aggressive therapy may still be appropriate, including use of critical care units, transfusion, intubation or surgery.
- The decision whether or not to resuscitate a particular patient is the responsibility of the attending physician in consultation with the patient. Each case is unique and decisions must be guided by medical, ethical, legal and social factors. Competent adults may choose to accept or reject resuscitation without affecting other modes of therapy.
- In the case of patients who are terminally ill, it is the responsibility of the attending physician to document whether or not cardiopulmonary resuscitation is to be performed.
- In non-competent patients with a terminal illness, where death is not unexpected, the decision not to resuscitate should be discussed with, and concurred in, by their guardian, or by the person who has been given a legal authority over healthcare decisions for the patient, such as a surrogate named in a legally binding document signed by the patient. If there is no guardian or legal surrogate, and no document expressing the patient's wishes is available, those closest to the patient should be consulted and their concurrence obtained. Documentation that this discussion has taken place will be made in the patient's chart.

- It is the policy of the Good Samaritan Hospital is to provide the highest quality medical care to its patients. The presumptive standard of care requires full resuscitative measures if cardiac arrest occurs. The conditions which justify withholding full resuscitative measures are:
 - A written Do Not Resuscitate (DNR) order;
 - A licensed physician (who knows the patient and exercises sound medical judgment) giving an instruction not to institute resuscitation of a patient who has just experienced an arrest;
 - A legally binding document indicating the patient's wishes for forgo resuscitative measures.



TITLE: FAIR HEARING PLAN AND APPELLATE REVIEW	SEARCH WORD: Fair Hearing Plan and Appellate Review
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

FAIR HEARING PLAN AND APPELLATE REVIEW

A. RIGHT TO HEARING AND APPELLATE REVIEW

1. When any practitioner receives notice of a recommendation of the Medical Executive Committee that if ratified by the Board will adversely affect the practitioner's appointment to or status as a member of the Staff or exercise of clinical privileges, the practitioner shall be entitled to a hearing before an ad hoc committee of the Staff. If the recommendation of the Medical Executive Committee after considering the recommendation of the ad hoc committee is still adverse to the affected practitioner, the practitioner shall then be entitled to an appellate review by the Board before the Board makes a final decision.
2. When any practitioner receives notice of a proposed action from the Board that if taken will adversely affect his/her appointment to or status as a member of the Staff or exercise of clinical privileges, and such proposed action is not based on a prior adverse recommendation by the Medical Executive Committee with respect to which the practitioner was entitled to a hearing and appellate review, the practitioner shall be entitled to a hearing by a committee appointed by the Board, before the Board makes a final decision on the matter.
3. The following recommendations or actions shall be deemed adverse for the purpose of paragraphs (1) and (2) above: denial of initial Staff appointment, denial of reappointment, suspension of Staff membership (except in the case of automatic suspension), revocation of Staff membership, denial of requested advancement in Staff category, reduction of admitting privileges, denial of requested area affiliation, denial of requested clinical privileges, reduction in clinical privileges, suspension of clinical privileges, revocation of clinical privileges, terms of probation, or requirement of consultation.

B. REQUEST FOR HEARING

1. Notice of Adverse Decision

Within ten (10) calendar days of the recommendation or decision, the Administrator, acting as agent for the Medical Executive Committee, shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review. The notice shall clearly state the reasons for said

adverse recommendation or decision, and shall be given in the form prescribed by Section A (3).

2. Waiver of Rights of Hearing and Appellate Review

The practitioner may request a hearing, in writing, by registered mail, certified mail, or by personal delivery to the Administrator, within thirty (30) days of his/her receipt of written notice of the adverse recommendation or decision. The failure of a practitioner to request a hearing to which he/she is entitled by these Bylaws within thirty (30) days of his/her receipt of written notice shall be deemed a waiver of right to such a hearing and to any appellate review to which he/she might otherwise have been entitled. The failure of a practitioner to request an appellate review to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review.

3. Effect of Waiver

When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Board, the same shall thereupon become and remain effective against the practitioner pending the Board's decision on the matter. When the waived hearing or appellate review related to an adverse decision by the Board, the same shall thereupon become and remain effective against the practitioner in the same manner as a final decision of the Board provided for in Section I below. In either of such events, the Administrator shall within ten (10) calendar days of such waiver notify the affected practitioner of his/her status by registered mail, certified mail, or by personal service.

C. NOTICE OF HEARING

1. Schedule of Hearing

Within ten (10) calendar days after receipt of a request for hearing from a practitioner entitled to the same, the Medical Executive Committee of the board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the Administrator, notify the personal service. The hearing date shall not be less than thirty (30) days from the date of receipt of notice of hearing, unless the members of the hearing committee and the affected practitioner mutually agree that the hearing be held sooner. A hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but in no event later than thirty five (35) days from the date of receipt of the request for hearing.

2. Content of Notice

The notice of hearing shall state in concise language the acts or omissions with which the practitioner is charged and/or the other reasons for the adverse recommendation or decision, and shall include, to the extent known, a list of witnesses who may be called to testify against the practitioner.

D. COMPOSITION OF HEARING COMMITTEE

1. When a hearing relates to an adverse recommendation of the Medical Executive Committee, the Medical Executive Committee, acting through the Chief of Staff, shall recommend to the Board a hearing committee of not less than three (3) staff members, with one of the members so appointed designated as Chair. The Medical Executive Committee may, in its discretion, include one or more non-Physician members on the hearing committee, with or without the right to vote, so long as a majority of the hearing committee shall consist of physicians. Unless the Board provides written objection to the Medical Executive Committee within five (5) calendar days of receiving notice of the selection of the recommended hearing committee, the Board shall be deemed to have approved the selection. The hearing committee shall be composed of unbiased individuals who shall gain no direct financial benefit from the outcome and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the same matter. Whenever practical, the hearing committee shall include an individual practicing in the same specialty as the practitioner. Where the Chief of Staff is unable to secure the required number of qualified hearing committee members from the Staff members, he/she may, with the approval of the Medical Executive Committee, appoint such qualified practitioners who are not Staff members as are needed to complete the committee.
2. When a hearing relates to an adverse decision of the Board that is contrary to a favorable recommendation of the Medical Executive Committee, the Board shall appoint a hearing committee of five (5) members to conduct such a hearing and shall designate one of the members as a Chair. At least two representatives from the Staff shall be included on this committee. The hearing committee shall be composed of unbiased individuals who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the same matter.
3. In the case of all hearings, whether related to an adverse recommendation of the Medical Executive Committee or related to an adverse decision of the Board that is contrary to a favorable recommendation of the Medical Executive Committee may, and shall if requested by the affected practitioner, select a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law, other than the Hospital attorney, who is unbiased, experienced in hospital/medical staff relations and who is appropriately qualified to preside over the hearing. The Hospital shall be responsible for compensating the hearing officer as is appropriate. Aside from such compensation for services, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer and advocate, and shall not be entitled to vote.

E. PRE-HEARING PROCEDURE

1. The practitioner shall have a reasonable opportunity to challenge the impartiality of the hearing committee and the hearing officer. The hearing committee Chair, or the hearing officer if one is appointed, shall be the presiding officer and shall rule on all such challenges not later than seven (7) calendar days prior to the scheduled date of the hearing.

2. The practitioner shall have the right, as soon as practicable after the hearing has been requested, to inspect and copy, at his/her own expense, any non-privileged documents, charts, correspondence, or other evidence upon which the charges are based and which is reasonably necessary to enable the practitioner to prepare a defense. This shall include all evidence, which was considered by the Medical Executive Committee or the Board in bringing the adverse action, as well as any exculpatory or arguably exculpatory evidence, which is in the possession of the Hospital or Medical Staff. The failure of the Medical Executive Committee, the Board or the Hospital to make this evidence available to the practitioner within a reasonable period of time before the hearing shall, in the reasonable discretion of the presiding officer, constitute grounds for a continuance of the hearing.
3. The Medical Executive Committee or the Board, as appropriate, shall have the right, as soon as practicable after the hearing has been requested, to inspect and copy, at its own expense, any non-privileged document or other evidence relevant to the subject matter of the hearing which the practitioner has in his/her possession. The failure of the practitioner to make this evidence available to the Medical Executive Committee or the Board within a reasonable period of time before the hearing shall, in the reasonable discretion of the presiding officer, constitute grounds for a continuance of the hearing.
4. The presiding officer shall have the sole discretion to rule upon any pre-hearing request for continuance, inspection, copying, or other access to information.

F. CONDUCT OF COMMITTEE HEARING

1. Presence of Practitioner

No hearing shall be conducted without personal presence of the practitioner for whom the hearing has been scheduled unless the practitioner waives such appearance or fails without good cause to appear for the hearing after notice of the hearing. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights under Subsection 8 of this Section F; provided, however, the practitioner shall retain his/her rights under Section H below. The question of good cause shall be within the sole discretion of the presiding officer.

2. Postponements

Postponements of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the presiding officer. Granting such postponements shall only be for good cause shown and in the sole discretion of the presiding officer

3. Records

An accurate record of the hearing shall be kept by a court reporter or electronic recording unit. The affected practitioner shall have the right to obtain a copy of the record of the proceeding.

4. Representation of Practitioner

The affected practitioner shall be entitled to select, to accompany and/or represent himself/herself at the hearing, a Staff member in good standing, a member of his/her professional society, or an attorney.

5. Determination of Procedure

The presiding officer shall determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

6. Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objections in civil and criminal actions. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure, or of fact, and such memoranda shall become part of the hearing record.

7. Representation of Medical Executive Committee and Board

The Medical Executive Committee, when its action is the subject of the hearing, other Staff member, the Staff attorney, or some other attorney to present the facts in support of the adverse recommendation and to examine witnesses. The Board, when its action is the subject of the hearing, shall appoint one of its members of the Hospital Authority to present the facts in support of the adverse decision and to examine witnesses. Said person shall not be entitled to vote in the adoption of a recommendation. It shall be the obligation of such person to present appropriate evidence in support of the adverse recommendation or decision. The affected practitioner may support his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis or the action taken thereon is either arbitrary, unreasonable, or capricious. An adverse action should be imposed only on the basis of a finding by the hearing body of substantial evidence to support the grounds for the adverse action.

8. Rights of Practitioner

The affected practitioner shall have the following rights: to call and examine witnesses; to introduce written evidence; to hear or otherwise observe all evidence offered in connection with such hearing; to cross-examine any witnesses on any matter relevant to the issue of the hearing; to submit a written statement at the close of the hearing; to challenge the credibility of any witness; and to rebut any evidence. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination. The Staff attorney and the Hospital attorney may be present.

9. Recess

Ether hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

10. Deliberations

Upon the closing of the hearing, the hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the practitioner for whom the hearing was convened. Any hearing officer may participate in the deliberations of the hearing committee and offer advice, but the hearing officer shall not be entitled to vote.

11. Report and Recommendations

Within ten (10) calendar days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation with reasons and facts upon which the recommendation is based and shall forward the same together with the hearing record and all other documentation to the Medical Executive Committee or to the Board, whichever, appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or decision of the Board. The report does not have to recommend a penalty but can state conclusions only as to whether a cause for action exists. The appointing body may at its discretion request the presence or absence of recommended penalty in its appointment.

G. RECONSIDERATION BY MEDICAL EXECUTIVE COMMITTEE OR BOARD

1. Recommendation or Decision

Within ten (10) calendar days after receiving the report and recommendation of the hearing committee, the Medical Executive Committee or the Board, whichever appointed the committee, shall meet and consider said report and recommendation. The appointing body shall make its recommendation or decision whether to accept or reject the recommendations of the hearing committee, and the Chair of the hearing committee shall transmit notice of this recommendation or decision to the Administrator.

2. Within ten (10) calendar days after receiving the recommendation of decision from the Medical Executive Committee or the Board, the Administrator, acting as agent for the Medical Executive Committee or Board, as may be the case, shall be responsible for giving prompt written notice of an adverse recommendation of decision to the affected practitioner who is entitled to an appellate review, including a copy of the written recommendations of the hearing committee. The notice shall clearly state the recommendation or decision and the basis of said adverse recommendation or decision; advise the practitioner of his/her rights to an appellate review pursuant to Section H below; specify that he/she shall have fourteen (14) days following the date of receipt of said notice within which to request an appellate review; state that failure to waiver his/her rights to the same; state that upon receipt of his/her request,

he/she will be notified of the date, time and place for the appellate review; advise him/her of his/her right to review the hearing records and report, if any, and to submit a written statement in his/her behalf as part of the appellate procedure; and advise him/her of his/her right to the assistance of legal counsel or a fellow practitioner in the preparation of said brief and the representations of legal counsel or a fellow practitioner at the appellate review.

H. APPEAL TO THE GOVERNING BODY

1. Notice of Request for Appellate Review

Within thirty (30) days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Board delivered through the Administrator, request an appellate review by the Board. Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

2. Waiver of Right to Appellate Review

If such appellate review is not requested within thirty (30) days, the affected practitioner shall be deemed to have waived the right to same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Sections B (2) and (3) above.

3. Scheduling of Appellate Review

Within ten (10) calendar days after receipt of such notice or request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Administrator, notify the affected practitioner in writing of the same. The date of the appellate review shall not be more the ten (10) calendar days from the date of receipt of the notice of request for appellate review, unless additional time is requested by the affected practitioner.

4. Board Members Required

The appellate review shall be conducted by the Board, acting as a committee of the whole, with not less than a majority of its members present.

5. Written Statements

The affected practitioner shall have access to the report and record of the hearing committee and all other non-privileged material, favorable or unfavorable, that was considered in making the adverse recommendation or decision. The practitioner may submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is

related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Board five (5) calendar days prior to the date set for such appellate review. A similar statement may be submitted by the Medical Executive Committee or by the Chair of the hearing committee appointed by the Board, and if submitted, the Administrator shall provide a copy thereof to the practitioner at least three (3) calendar days prior to the date of such appellate review.

6. Review

The Board shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted for the purpose of determining whether the adverse recommendation or decision against the affected practitioner should be upheld. If oral argument is requested as part of the review procedure, the affected practitioner should be upheld. If oral argument is requested as part of the review procedure, the affected practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body.

7. Consideration of New Matters

New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review (a) upon a showing of good cause or previous unavailability of such material, or (b) to show the practitioner's present compliance or non-compliance with Rules and Regulations of the Staff or with prior decisions to the Medical Executive Committee or Board. The Board shall in its sole discretion, determine whether such new matter(s) shall be accepted.

8. Board Action

The Board may affirm, modify or reverse the prior decision, or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within ten (10) calendar days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specific.

9. Conclusion of Appellate Review

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section H have been completed or waived.

I. FINAL DECISION BY GOVERNING BODY

1. Board Decision

Within ten (10) calendar days after the conclusion of the appellate review, the Board shall make its final decision in the matter. The decision shall be in writing including the basis for the decision, and a copy and notice thereof shall be sent to the Medical Executive Committee and through the Administrator, to the affected practitioner by certified mail, registered mail, or by personal delivery within ten (10) calendar days from the decision. This decision shall be immediately effective and final, and shall not be subject to further hearing or appellate

review; provided however, that if the Board's decision has the effect of changing the Medical Executive Committee's last such recommendation, if any the decision shall not be considered final and the Board shall immediately refer the matter to the Joint Conference Committee. Within (10) calendar days of the referral of the Board's decision, the Joint Conference Committee shall commence the disputer resolution process as provided in Article Dispute Resolution. Unless the matter proceeds to arbitrations under Dispute Resolution, Section C (3), then upon completion of the dispute resolution process described in the Dispute Resolution, the Board's action on the matter following receipt of the Joint Conference Committee's recommendation shall be immediately effective and final.

2. Conclusiveness of Appellate Review

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled by right to more than one hearing and one appellate review on any matter, which shall have been the subject of action by the Medical Executive Committee or by the Board.

3. Report to State Licensing Board

Within fifteen (15) days from the date of the Board's final decision on any action taken in the course of professional review activity which:

- a. Is based on the professional competence or conduct of a Staff member, which adversely affects or could adversely affect the health or welfare of patient(s);
- a. Which adversely affects or may adversely affect the practitioner's clinical privileges or Staff membership for longer than thirty (30) days. The administrator, acting on behalf of the Staff, shall submit to the affected practitioner's state licensing board a report identifying the affected practitioner and any adverse action taken. The Administrator and the Staff shall be jointly responsible for the accuracy of the information reported; shall act promptly to submit additional information as needed to correct errors or omissions found after the information is originally reported; and shall also promptly report any revision of the action originally reported, including reversals. No civil liability or any cause of action shall arise against any Staff member, member of the Board, or Administration as a result of having complied with this reporting requirement so long as such person acts in good faith and without malice.



TITLE: GENERAL RULES REGARDING SURGICAL CARE	SEARCH WORD: Surgical Care
DEPARTMENT: Medical Staff	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

GENERAL RULES REGARDING SURGICAL CARE

- Every attempt should be made to perform operations on an outpatient, or if not possible, on a day-of-surgery admission basis.
- The history and physical examination should be recorded prior to the time stated for a surgical procedure, except in emergencies. If they are not, the surgery shall be canceled unless the surgeon states in writing in the medical record that such delay would constitute a hazard to the patient.
- Surgical operations, other than emergency procedures, shall not be performed until adequate clinical data, which may include radiology and laboratory results, are recorded on the chart. In emergency cases, the surgeon will write a brief note indicating the emergent nature of and indications for the procedure to be done. All laboratory requirements must be waived by the surgeon and the anesthesiologist.
 - Emergency surgery is defined as life threatening or those procedures in which failure to initiate surgery within one hour will likely result in irreparable harm to the patient.
- Surgical operations and other invasive diagnostic and therapeutic procedures shall be undertaken only when the prior, informed, voluntary consent of the patient or, where appropriate his/her legal representative, has been obtained in accordance with hospital policy. The written informed consent(s) shall be in the medical record before the surgical procedure is begun.
- Written, signed, informed surgical consent shall be obtained within 30 days prior to an operative procedure by the responsible staff professional except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving an unconscious patient in which consent for surgery cannot be immediately obtained from next of kin, these circumstances should be fully explained in the patient's medical record by the operating staff surgeon. It is advisable that another physician member of the medical staff, familiar with the patient's condition, be consulted for his/her concurrence. Hospital forms will be used and the name of the operating surgeon and supervisory staff surgeon will be on the consent form.

- All tissues and materials removed during surgery shall be sent to the Lab and then sent to the contracted pathology lab for examination or disposition as is necessary to arrive at pathological diagnosis. The specimen shall be adequately labeled as to patient's name and tissue sources, and shall be accompanied by a tissue examination form with pertinent identification and clinical information. A signed report will be issued to document the pathologic diagnosis. All tissue shall remain the property of the under the custody of the Contracted Lab providing Pathology services.
- The operating surgeon shall have a qualified physician or oral surgeon as his/her assistant for all major operations. The assistant in a major operation must be another surgeon. Medical students should act only in a second, third or fourth assistant capacity at major operative procedures in accordance with St. Mary's Good Samaritan regulations.
- Medical students may be permitted to perform minor surgery such as closure of minor wounds and incisions, minor excision of cysts, etc., under the direct supervision of a qualified physician.
- There must be evidence in the medical record of a pre- and a post anesthesia visit by a member of the anesthesia care team. A post anesthesia visit shall be made during the time the patient is in the Post Anesthesia Care Unit. If possible, a second visit should also be made after the patient has left the post anesthesia care unit. The PACU note will describe the presence or absence of anesthesia-related complications. PACU medical information should include vital signs, level of consciousness on entering and leaving this recovery area, status of infusion, status of surgical dressings, and status of any tubes, catheters or drains and presence and quality of pain.
- The release of every patient from the PACU shall be in accordance with the PACU policy.
- Operative reports should be dictated or written in the medical record immediately after surgery. They should contain a description of the findings, technical procedures used, specimens removed and disposition of same, postoperative diagnosis, estimated blood loss, if any, and name of the primary surgeon, and any assistants.

TITLE: GUIDELINES FOR GRANTING OF LAPAROSCOPIC CHOLECYSTECTOMY OR APPENDECTOMY		SEARCH WORD: Laparoscopic Cholecystectomy or Appendectomy	
DEPARTMENT: Medical Staff			
PRESIDENT APPROVAL:		MEDICAL DIRECTOR APPROVAL:	
EFFECTIVE DATE:		UPDATED: 8/28/15	

GUIDELINES FOR GRANTING OF LAPAROSCOPIC CHOLECYSTECTOMY OR APPENDECTOMY

- The surgeon must have assisted on five (5) laparoscopic cholecystectomy cases and been proctored for five (5) cholecystectomy laparoscopic cases which he/she was the primary operator, before full privileges may be considered.
- The proctor must be a Board Certified General Surgeon with full biliary privileges; proper laparoscopic training - preferably on staff at Good Samaritan Hospital. These cases may be submitted from any recognized accredited hospital.
- Once a general surgeon has been proctored for laparoscopic cholecystectomy, he/she will not have to be proctored for laparoscopy.



TITLE: HARASSMENT PROHIBITED	SEARCH WORD: Harassment Prohibited
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL
EFFECTIVE DATE:	UPDATED: 8/28/15

HARASSMENT PROHIITED

- Harassment by a medical staff member against any individual (i.e., against another medical staff member, house staff, hospital employees or patients) on the basis of race, religion, color, national origin, age, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, sexual orientation or any other characteristic protected by state and/or federal law shall not be tolerated.
- Sexual harassment is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoon drawings, or posters).
- *Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, physical conduct of a sexual nature when:*
 - *Submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment, or*
 - *This conduct substantially interferes with the individual's employment or creates an intimidating, hostile or offensive work environment.*
- *Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.*
- All allegations of harassment shall immediately be jointly investigated by the medical staff and administration and if confirmed, will result in appropriate corrective action, from reprimands up to and including summary suspension or forced leave of absence, termination of medical staff membership or clinical privileges as per the terms of the Hospitalwide Harassment Policy, if warranted by the facts.



TITLE: INCIDENT AND SENTINEL EVENT REPORTING	SEARCH WORD: Incident and Sentinel Event
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

INCIDENT AND SENTINEL EVENT REPORTING

All incidents where a medical staff member is involved that either has caused patient death, complication(s) not normally associated with the patient’s disease process or surgical procedure, or harm; or has the potential of causing harm, must be promptly reported by the person witnessing/discovering the incident. This includes incidents where there is evidence that medical devices and/or medications have caused or contributed to an incident in which a serious illness, injury or death of a patient occurred.

SENTINEL EVENTS:

Unexpected events or occurrences involving death or serious physical or psychological injury, or the risk thereof (i.e., sentinel events), are to be reported to the Quality Management Department immediately upon identification. Any sentinel event requires immediate action to examine, indepth, the event to determine why the incident occurred and how to reduce the likelihood of recurrence.

DEFINITIONS:

- Adverse Event: An event or occurrence which results in significant patient injury or impairment. (Example: Transfusion, drug or anesthesia reaction resulting in significant condition change in the patient)
- Sentinel Event: Unexpected adverse occurrence involving death or serious injury or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. A sentinel event is an adverse event of a severe and urgent nature that can result in an unexpected and undesirable patient outcome. (Example: Surgery on the wrong patient or removal of the incorrect limb)
 - A sentinel event:
 - Potentially involves a continuing threat to patient care or safety;
 - Has significant potential for being reflective of serious underlying systems problems within an organization;
 - Potentially undermines public confidence in the organization.

PROCEDURE:

- Upon notification of sentinel event occurrence, St. Mary's Good Samaritan will immediately conduct an analysis of all factors involved with the event, in an effort to determine why the incident occurred. This analysis is defined as a "Root Cause Analysis", because the objective of the analysis is to determine the basic, causative factor(s) that led to the event.
- Sentinel events will be reviewed by the administrative team and the Director of Quality Management within 24 hours of incident identification. The administrative team will determine if the incident requires an intensive assessment resulting in a root cause analysis, pursuant to preestablished criteria (indicators) which define actual or near occurrence of sentinel events.
- While not always required, a root cause analysis is generally conducted by a collaborative organizational team, whose members have specific knowledge and authority to determine and correct the identified causative factors of the sentinel event. The Director of Quality Management will formulate recommendations for team membership and forward this to the administrative team for their approval. The administrative team will direct commencement of the root cause analysis by the designated team, within the next business day of their notification. In no instance will commencement of the analysis team begin over 72 hours from the date of the sentinel event identification.
- If the root cause analysis finds the sentinel event to be caused by the performance and/or competence of a practitioner holding clinical privileges, the corrective action will be managed through the outlined medical staff committee process, under the supervision and direction of the Medical Executive Committee.
- If the root cause analysis finds the sentinel event to be caused by the performance and/or competence of a clinical staff member not holding clinical privileges, or of a non-clinical staff member, then the corrective action shall be managed by the department manager, in conjunction with the administrative team.
- If the root cause analysis determines that the sentinel event is related to an organizational systems or process problem, the team will utilize the organizational performance improvement model to design, implement and evaluate an improvement plan to correct the system issue and/or problem.
- The analysis team will focus on the root causes of the event or occurrence, conducting the analysis in accordance with the suggested guidelines from the publication *Conducting a Root Cause Analysis in Response to a Sentinel Event*, published and distributed by The Joint Commission.
- Action plans will be developed with objectives that are formulated in an effort to prevent recurrence or the potential thereof, of the sentinel event.
- All analysis teams will include a member of the administrative team, or their specifically appointed designee. The analysis team will report any and all activities to the administrative team, as they occur.
- The analysis team will be afforded the time and resources by the administrative team to implement the approved action plan.

- The analysis team will not, in any circumstance, delay implementation of the action plan or, as appropriate, elements of its components, over seven days from the date of the sentinel event identification.
- The improvement plan determined by the analysis team, and the plan results, will be reported to the organizational administrative team, Performance Improvement Committee, appropriate committees of the medical staff, Governing Body and, at the direction of the administrative team, any other committees, teams, workgroups or individuals within the organization, as appropriate to the defined issue.
- The sentinel event and/or the corrective plan will be communicated to other organizations or individuals at the sole discretion of the Chief Executive Officer or his/her specific designee.
- The following is an established list of sentinel events related to this policy and procedure. It is understood that all high-risk events are reviewed by the administrative team, and at the direction of the administrative team, a root cause analysis may be requested for events that do not fall under the sentinel event criteria.

SENTINEL EVENT CRITERIA:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of a patient in a setting where the patient receives around-the-clock care or within 72 hours of discharge from an around-the-clock setting.
 - Infant or child discharge to the wrong family
 - Unanticipated death of a full-term infant
 - Abduction of any patient receiving care, treatment and services
 - Rape (by another patient, visitor or staff)
 - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
 - Surgery on the incorrect patient or incorrect body part
 - Unintended retention of a foreign object in a patient after surgery or other procedure
 - Prolonged fluoroscopy with cumulative dose >1500rads to a single field.

TITLE: INDICATIONS FOR THE USE OF FRESH FROZEN PLASMA AND PLATELETS IN THE OPERATING ROOM		SEARCH WORD: Plasma and Platelets
DEPARTMENT:		
PRESIDENT APPROVAL:		MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:		UPDATED: 8/28/15

INDICATIONS FOR THE USE OF FRESH FROZEN PLASMA AND PLATELETS IN THE OPERATING ROOM

- Congenital Factor Deficiencies that require immediate treatment.
- Acquired Factor and Platelet Deficiencies that require immediate treatment. (This is more common in the perioperative period.)
 - Anticoagulants
 - Liver Disease
 - Idiopathic Thrombocytopenia Purpura (ITP)
 - Disseminated Intravascular Coagulation (DIC)
 - Dilution of Coagulation Factors/Platelets
 - Depletion/destruction of coagulation factors and platelets (i.e., prolonged Cardiopulmonary Bypass)
- Massive transfusion with packed RBC/washed RBC
- Dilutional effects of crystalloids when priming heart-lung machine (i.e., small blood volume patients and pediatric patients)
- When perioperative bleeding occurs, surgical hemostasis is evaluated, circulating anticoagulants are measured. Pharmacologic treatment is maximized when appropriate coagulation panel is drawn (PT, PTT, fibrinogen, Platelets) and Sonoclot is performed to evaluate platelet quality when laboratory results are pending and immediate treatment is needed (i.e., generalized oozing/bleeding). FFP/platelets will often need to be ordered prior to receiving laboratory results.



TITLE: INFECTION PREVENTION AND CONTROL	SEARCH WORD: Infection Prevention and Control
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

INFECTION PREVENTION AND CONTROL

Healthcare associated infections are potential hazards to all persons having contact with a hospital. The major safety initiative of the Infection Prevention and Control program at Good Samaritan Hospital is the prevention of healthcare associated infections thus providing a safe and health environment for all patients, visitors, and employees; including rotating, temporary, volunteer and medical staff.

The main elements of this program include adherence to the principles of Standard precautions for all patient contact, and blood and body fluid, surveillance and analysis of healthcare associated infections and staff education. It is the responsibility of all hospital personnel to comply with hospital infection control policies.

For further details, see the Hospital Infection Prevention and Control Program in the Hospital Infection Prevention and Control Manual. For specific guidance on HIV infection, see Hospital policy "Human Immunodeficiency Virus Antibody Testing" and Human Immunodeficiency Virus Antibody Testing and Counseling of Staff".

Patient with known or suspected communicable infections are admitted and the appropriate isolation precautions instituted as indicated in the Infection Prevention and Control Manual. Contacting the Infection Control Nurse and/or the Physician adviser for the Infection Prevention and Control Committee can facilitate implementation of isolation precautions. The Infection Control Nurse in consultation with physician advisor of the Infection Control Committee will act as liaison in those matters affecting the infection potential of the hospital environment.



TITLE: INFORMED CONSENT	SEARCH WORD: Informed Consent
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

INFORMED CONSENT

- Informed consent is required before administration of anesthesia or performance of procedures that are invasive or potentially hazardous, including blood transfusions and certain tests. Prior to performance of an operative or other invasive procedure, the responsible practitioner will obtain informed consent from the patient or his/her representative.
- It is the right of the patient and a policy of Good Samaritan Hospital, that patients may accept or refuse treatment offered to them. The patient is to be given all information necessary to explain the risks, benefits, potential complications, alternatives and options to any operative and/or invasive procedure, prior to performing the procedure. Written consent is required before any major treatments or procedures are initiated. The written consent is to verify that the patient has been clearly informed regarding the nature of the procedure or treatment to be undertaken, the risks and benefits of the treatment, alternatives and options to consider and the expected outcome if the treatment is declined.
- The practitioner who has primary responsibility for the patient or who will be performing the procedure/treatment is responsible for informing the patient and for obtaining the written consent in the presence of a qualified witness. Documentation of the Informed consent and the Informed consent discussion must be made in the patient's medical record. The patient record must indicate what was communicated, what risks/benefits were discussed with the patient and if the patient had difficulty understanding the discussion.
- All items on the Consent Form must be completed, signed, witnessed, timed and dated according to organizational policy.
- Informed consent must be obtained from the patient's appointed surrogate, conservator or next-of-kin if the patient is unable to understand or give consent. If the patient does not have a surrogate or conservator, certification by the attending physician must be documented along with a statement by a staff member of the hospital's Social Service Department that no legally appointed guardian or willing family member or close friend is available. The Chief of Medical Staff or designee must then provide written concurrence with the treatment decision. The reason why the patient is unable to provide consent must be documented.

- When it is necessary to obtain consent by telephone, the conversation must be verified by a second licensed professional. Both professionals shall sign the consent as witnesses. Telephone consent from (insert name of person giving consent) shall be written in the patient signature area. The name and phone number of the person giving consent, must be documented in the progress notes.

- In instances where the patient is unable to give consent and/or the surrogate is not readily available, and treatment is necessary as an emergency life-saving measure or to prevent loss of limb or body part, informed consent may be waived. This instance is to be utilized only as an emergency measure, and requires that the treating physician document in the medical record: the nature of the emergency, the planned treatment and/or procedure, the potential harm to the patient if the emergency treatment and/or procedure is delayed, the inability of the patient to consent and unavailability of surrogates/guardian/family members to provide consent. The physician must be sure to document that the treatment and/or procedure are being performed as an emergent life-saving and/or limb/body part saving measure. It is advisable to have concurrence from another physician who is familiar with the patient's condition and circumstances, and to have this concurrence documented in the medical record, although signature of two (2) physicians to perform an emergency procedure without patient/family consent is not required.

- All medical staff members are responsible for adhering to St. Mary's Good Samaritan's policy for Informed Consent.

- Requirements for Consent:
 - No surgical or invasive procedure and no treatment involving unusual risk to the patient (including blood transfusion) shall be performed without both of the following documented in the record:
 - Informed Consent:
 - ◆ It shall be the responsibility of the operating physician, dentist or podiatrist to obtain an informed consent of a patient or legally authorized representative. Informed consent shall include at least the following:
 - An explanation of the procedure, appropriate alternatives and respective benefits;
 - An explanation of the significant risks, complications and alternative options. The patient may be informed that he or she has the right to refuse this explanation;
 - An explanation of the possible consequences of refusing the proposed treatment or procedure;
 - The physician, dentist or podiatrist shall document in the medical record that an informed consent has been obtained.
 - Consent to Treatment:

- ◆ The patient's written consent to treatment must be documented on an approved hospital form. It shall be the responsibility of the practitioner to provide the admitting nurse (or appropriate nursing personnel on the unit) with a written or verbal order indicating the name of the procedure to be performed.

- ◆ Informed consent for psychotropic medications shall be obtained in accordance with applicable hospital policy.

TITLE: LIFE SUPPORT AND PRONOUNCEMENT	SEARCH WORD: Life Support and Pronouncement
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

LIFE SUPPORT AND PRONOUNCEMENT

SUPPORT AND PRONOUNCEMENT OF DEATH:

- The attending medical doctor is responsible for completing the practitioner's order for CPR status-Withholding/Withdrawing Life Sustaining Medical Intervention whenever foregoing life support is contemplated, as defined in these Rules and Regulations.
- In the event of a hospital death, the attending practitioner or designee shall pronounce the deceased. The body shall not be released until an entry has been made and authenticated in the medical record of the deceased by a medical or osteopathic member of the medical staff. Policies with respect to release of the remains shall conform to local law.

DEFINITION OF TERMS:

- **Life Sustaining Treatment:** Any type of intervention which replaces or sustains body functions including but not limited, to mechanical ventilation, balloon pump therapy, dialysis, cardiac pacing, vasopressor therapy, gastrostomy tube placement, nutritional support and hydration. All life sustaining treatment is considered equivalent both legally and ethically.
- **Do Not Resuscitate /No Code (DNR):** A written physician order instructing hospital personnel that resuscitation services are not to be provided in the event of cardiopulmonary arrest.
- **Withholding of Medical Treatment:** A conscious decision not to provide an intervention that may sustain life.
- **Withdrawing of Medical Treatment:** The removal or cessation of any existing intervention that may sustain life.



TITLE: ONGOING & FOCUSED PROFESSIONAL PRACTICE EVALUATION	SEARCH WORD: Ongoing & Focused Professional Practice Evaluation
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE: 2008	REVIEWED DATE: 08/28/2015

ONGOING & FOCUSED PROFESSIONAL PRACTICE EVALUATION

PURPOSE:

To establish guidelines for Ongoing and Focused Professional Practice Evaluation, in order to assess the professional performance of practitioners at St. Mary's Good Samaritan, in compliance with Joint Commission standards and in order to foster a more efficient, evidence-based privileging process and evaluation/improvement of patient care.

DEFINITIONS:

A. Focused professional practice evaluation means a time-limited process whereby St. Mary's Good Samaritan, with the assistance of its medical staff:

1. Evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital (or whose credentials suggest competence but additional information or a period of evaluation is needed to confirm competency in the Hospital's setting); and
2. Evaluates the competence of a currently privileged practitioner when questions arise regarding that practitioner's ability to provide safe, high quality patient care.

B. Ongoing professional practice evaluation means an evaluation of a practitioner's clinical competence and professional behavior, on an ongoing, routine or continuous basis. Ongoing professional practice evaluation is used to assess the quality of care of currently privileged practitioners. Ongoing professional practice evaluation information should be factored into St. Mary's Good Samaritan decisions to:

1. Maintain a practitioners existing privilege(s);
2. Revise a practitioner's existing privilege(s); or
3. Revoke a practitioner's existing privileges prior to or at the time of renewal.

PROCEDURE:

Members of the Medical Staff are subject to having their professional practice and cases reviewed in an ongoing, focused, and/or otherwise periodic manner, for the purpose of improving the quality and safety of patient care. Focused and Ongoing Professional Practice Evaluation involves the medical staff and should be implemented in a consistent manner.

A. Focused Professional Practice Evaluation

Focused Professional Practice Evaluation should be implemented for all initially requested privileges. This includes a new applicant, an existing staff member who requests new privileges, an existing staff member who has existing privileges at the Hospital but who has no volume evidencing competency at the Hospital, and an existing staff member with existing privileges but a question has arisen regarding performance of a privilege.

Focused Professional Practice Evaluation should also occur when a question arises regarding a practitioner's ability during the course of Ongoing Professional Practice Evaluation, as outlined in this Policy.

1. St. Mary's Good Samaritan should focus the evaluation on competency related to the privileges sought or held by the practitioner.
2. The process should be clearly defined by the St. Mary's Good Samaritan medical staff and should include, but not be limited to, the following:
 - a. Criteria for conducting performance monitoring;
 - b. Method for establishing a monitoring plan specific to the requested privilege;
 - c. Method for determining the duration of performance monitoring; and
 - d. Circumstances under which monitoring by an external source is required.
3. The duties of St. Mary's Good Samaritan Medical Staff under Focused Professional Practice Evaluation includes, but are not limited to:
 - a. Evaluating practitioners without current performance documentation at the Hospital;
 - b. Evaluating practitioners in response to concerns regarding the provision of safe, high quality patient care;
 - c. Developing criteria for extending the evaluation period and/or assigning a different type of evaluation method;
 - d. Communicating to the appropriate parties the evaluation results and recommendations based on results; and
 - e. Implementing changes to improve performance.
4. Information used during the Focused Professional Practice Evaluation should include, but be limited to:
 - a. Chart review;
 - b. Monitoring clinical practice patterns;
 - c. Proctoring
 - d. External peer review; and
 - e. Discussion with other individuals involved in the care of each patient.

5. The decision to assign a period of performance monitoring to further assess current competence should be based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege. The Medical Staff should determine the criteria for extending the focused Professional Practice Evaluation Period.
6. While a practitioner's privilege-specific competency is being evaluated under the Focused Professional Practice Evaluation process, the other privileges held by that practitioner in good standing at the Hospital should not be adversely affected solely because of the decision to pursue Focused Professional Practice Evaluation.
7. Information resulting from the Focused Professional Practice Evaluation process should be incorporated into St. Mary's Good Samaritan performance improvement activities, consistent with St. Mary's Good Samaritan policies and procedures which state per review/medical review activities and proceedings are entitled to federal and state law immunities and privileges.
8. The Medical Staff should delineate the measures to be used to resolve performance issues identified, if any. These measures can include, but not be limited to: collegial intervention, letter of reprimand, recommendations regarding further education or training, proctoring, and/or referral to the Physician Peer Review Committee or Medical Staff Executive Committee. If a practitioner's conduct or performance involves possible imminent harm to a patient, staff member or Hospital employee, the Chief of Staff/or in his absence, administrative staff should be notified to assess whether suspension or another process should be utilized.
9. External peer review can be used, as determined to be necessary or appropriate by the Chief of Staff, President/Administrative Staff, including but not limited to: circumstances involving current or potential litigation; conflicting opinions; lack of internal expertise at the Hospital regarding privilege or particular issue; or other reasons as deemed appropriate by the Chief of Staff or such Committee Chairs.

B. Ongoing Professional Practice Evaluation

1. The criteria used by St. Mary's Good Samaritan Ongoing Professional Practice Evaluation may include, but not limited to, the following:
 - a. Review of operative and other clinical procedure(s) performed and their outcomes;
 - b. Pattern of blood and pharmaceutical usage;
 - c. Requests for tests and procedures;
 - d. Length of stay patterns;
 - e. Morbidity and mortality data;
 - f. Practitioner's use of consultants; and
 - g. Other relevant criteria as determined by St. Mary's Good Samaritan medical staff.
2. St. Mary's Good Samaritan may acquire information to be used in the Ongoing Professional Practice Evaluation through the following methods:
 - a. Periodic chart review;
 - b. Direct observation;
 - c. Monitoring of diagnostic and treatment techniques; and
 - d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

3. The process for Ongoing Professional Practice Evaluation should include, but not be limited to, the following:
 - a. A clearly defined process that facilitates the evaluation of each practitioner's professional practice;
 - b. The type of data to be collected as determined by individual departments and approved by St. Mary's Good Samaritan medical staff; and
 - c. Information resulting from the ongoing professional practice evaluation will be used to determine whether to continue, limit, or revoke any existing privilege(s).
4. Information resulting from the Ongoing Professional Practice Evaluation should be incorporated into St. Mary's Good Samaritan performance improvement activities, consistent with policies and procedures which state St. Mary's Good Samaritan peer review/medical review activities and proceedings are entitled to federal and state law immunities and privileges.
5. If, as a result of Ongoing Professional Practice Evaluation, a question arises regarding the practitioner's professional performance, the question can be referred to the Physician Peer Review Committee or Medical Staff Executive Committee for follow up, either as Focused Professional Practice Evaluation, or another process or corrective action as outlines in the medical staff bylaws for further evaluation of the practitioner. If the practitioner's conduct or performance involves possible imminent harm to a patient, staff member or Hospital employee, the Chief of Staff should be notified to assess whether suspension or another process should be utilized.

C. Additional Information:

1. All reports, recommendations, activities, proceedings and minutes made or taken pursuant to the Policy are confidential, privileged, and covered under the provisions of O.C.G.A § 31-7-131 *et.seq.*, O.C.G.A § 31-7-140 *et.seq.*, and the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et.seq.*
2. Ongoing and Focused Professional Practice Evaluations do not constitute an "investigation" under Article 6 of the Medical Staff Credentials Manual. If intervention taken would constitute corrective action triggering hearing rights under the Medical Staff Credentials Manual or Medical Staff Bylaws, then such practitioner is entitled to such hearing and appeal process.

D. Procedure for FPPEs

1. Five charts per physician will be reviewed.
2. Chief of Staff or department chief will sign off on the Focused Professional Practice Evaluations.
3. Completed forms will be forwarded to the medical staff office.

E. Procedure for OPPEs

1. OPPEs will be completed on all physicians by the quality department.
2. The physician will have access to information upon request.
3. Completed forms will be signed off by the chief of staff or department chief and then forwarded to the medical staff office at least annually.



TITLE: OPERATING ROOM ADMINISTRATIVE PROCEDURES	SEARCH WORD: Operating Room Administrative Procedures
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

OPERATING ROOM ADMINISTRATIVE PROCEDURES

SCHEDULING:

- Elective procedures are to be scheduled through the operating room from 8:00 AM to 4:30 PM, Monday through Friday. No elective procedures are scheduled on Saturdays, Sundays or holidays. Emergency procedures can be performed only during normal operating hours Monday – Friday from 8:00 AM – 4:30 PM, scheduled through the Surgical Department. If the OR is closed during normal operating hours due to no cases, a surgical team will be available for any emergency procedures that present to the ER. When scheduling inpatient or outpatient surgery, the following information is necessary:
 - Patient's name, age, operative procedure
 - Surgeon's name and assistant
 - Estimated length of procedure
- All cases are to be scheduled on a "first come, first served" basis. In all cases, reasonable estimate of the length of the case is required. Unreasonable estimates will not be accepted. Persistent inaccurate estimates by a surgeon will be brought to the attention of the Surgery Committee by the Surgical Services Nurse Manager.

SCHEDULING CONFLICT:

In cases of an emergent nature which may take precedence over already scheduled procedures, it is the responsibility of the surgeon requesting priority over the elective case to discuss the conflict directly with the scheduled surgeon. In the event of an impasse between the surgeons, the Chairperson of the department shall make the decision as to which case takes precedence.

ARRIVAL TIME:

The surgeon, assistant and anesthetist should arrive at least 15 minutes before the scheduled operating time. Late arrivals in excess of 20 minutes may result in the surgery being rescheduled or canceled by the Surgical Services Nurse Manager. Surgeons who are repeatedly late for their 8:00 AM operating room time may be denied that time in the future.

PATIENT IDENTIFICATION:

The responsibility of patient identification rests with the Surgical Services Nurse Manager, attending surgeon and anesthetist.

VISITORS:

Visitors must be cleared through the Surgical Services Nurse Manager, attending surgeon or anesthetist.

REQUIREMENTS FOR INPATIENT/OUTPATIENT SURGERY UNDER GENERAL ANESTHESIA/LOCAL ANESTHESIA WITH MONITORED ANESTHESIA CARE:

- Hospital consent form must be complete, properly signed and witnessed.
- History and Physical (with system review examination within seven (7) days). A preoperative note must be included on the chart giving medical assessment prior to the administration of general anesthesia.
- Documented CBC or hemogram at the discretion of the anesthetist and/or surgeon.
- Documented electrolytes within 30 days for patients on diuretic or digitalis medication, at the discretion of the anesthetist and/or surgeon.
- Ordering a preoperative EKG is left to the discretion of the attending surgeon and/or anesthetist.
- Documented copy of a chest x-ray within the last six (6) months, unless the attending physician indicates no chest x-ray shall be done.
- The anesthetist may, at his/her discretion, order additional lab work, chest x-ray or EKG as indicated.

REQUIREMENTS FOR OUTPATIENT SURGERY UNDER LOCAL ANESTHESIA:

- Hospital consent form is complete, properly signed and witnessed.
- Short history and physical (diagnosis, planned procedure, rationale for procedure, examination of body part to be operated upon, review of cardiac, pulmonary and mental status – at a minimum).
- CBC or hemogram, and urinalysis, if warranted.

REQUIREMENTS FOR EYE PROCEDURES:

- The preoperative history and physical for eye procedures must include:
 - Best visual acuity
 - Description of cataract
 - Condition of optic nerve

- Any other opacities of media
- Description of central retina
- Tension
- Any other eye findings appropriate to diagnosis
- Purpose of surgery



TITLE: ORGAN / TISSUE DONATION	SEARCH WORD: Organ / Tissue
DEPARTMENT:	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

ORGAN / TISSUE DONATION

Patients or their legal next-of-kin have a right to donate organs/tissue if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donations according to the established criteria. All deaths will be reported to the hospital's designated Organ/Tissue Donation Agency, with all organ and tissue donation performed in accordance with state and federal laws and other regulatory body requirements.

TITLE: PATIENT RIGHTS	SEARCH WORD: Patient Rights
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

PATIENT RIGHTS

- Respect for human rights shall be a basic tenet of Good Samaritan Hospital and its medical staff. All programs will support and protect the fundamental human, civil, constitutional and statutory rights of each individual patient.
- The care, treatment and rehabilitation services will be modified to meet the patient's needs taking into account disease severity and disabilities. Patients and/or their family members and/or designated representatives have the right to:
 - Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire;
 - Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care;
 - Considerate and respectful care, provided in a safe environment, free from all forms of abuse or harassment;
 - Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff;
 - Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her;
 - Receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand;
 - Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment;

- Participate in the development and implementation of his or her plan of care, and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment;
- Formulate advance directives regarding his or her healthcare, and have hospital staff and practitioners who provide care in the hospital comply with these directives (to the extent provided by state laws and regulations);
- Have a family member or representative of his or her choice notified promptly of his or her admission to the hospital;
- Have his or her personal physician notified promptly of his or her admission to the hospital;
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare;
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the hospital. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care;
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of request);
- Reasonable responses to any reasonable request he/she may make for service;
- Leave the hospital even against the advice of his/her physician;
- Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing the care;
- Be advised of the hospital grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the hospital contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date;
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the hospital;
- Know which hospital rules and policies apply to his/her conduct while a patient;
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient;

- Receive any information regarding human experimentation or research or education projects affecting their healthcare, and to refuse to participate in experimental or research protocols, if he/she chooses, without jeopardizing his/her care.
 - Organ/Tissue Donation:
 - ◆ Patients or their legal next-of-kin have a right to donate organs/tissue, if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donations according to the established criteria.
 - Human Research:
 - ◆ Patients have the right to agree to participate in research and, at the same time, they have the right to know that research requirements have been followed. The hospital is responsible for the protection of subjects from undue risk and from deprivation of personal rights and dignity. This protection is best ensured by consideration of two issues which are the touchstone of ethical research:
 - That voluntary participation by the subjects, indicated by free and documented informed consent.
 - That an appropriate balance exists between potential benefits of the research to the subject or to society and the risks assumed by the subject.
 - Therefore, Saint Joseph's at East Georgia and its medical staff will adhere to the guidelines of the Committee on Human Research and the Institutional Review Board.



TITLE: PATIENT TRANSFERS	SEARCH WORD: Patient Transfers
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

PATIENT TRANSFERS

- Good Samaritan Hospital, in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), along with all members of the medical staff, will comply with the policies regarding patient transfers and shall comply with all applicable laws regarding patient transfers.
- The medical record will reflect the reason for diagnostic testing, including laboratory and other invasive and noninvasive diagnostic testing and imaging procedures, relevant to the determination of the patient's healthcare or treatment needs.
- Patients shall not be transferred from Post Anesthesia Care Unit without a written order in the chart by the medical staff responsible for the patient's care and the completion of the appropriate transfer form.
- Transfers from one bed service to another will be accomplished only by mutual agreement of the bed services involved.
- There shall be a transfer note written on the progress notes by the transferring medical staff member or house staff. It shall be a concise recapitulation of the hospital course to date and developed to assist the receiving physician who assumes responsibility for the continuity of inpatient care.
- Patient transfer priorities are as follows:
 - From Post Anesthesia Care Unit to general care area.
- No patient will be transferred without such transfer being approved by the responsible practitioner.

TITLE: PEER REVIEW	SEARCH WORD: Peer Review
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	REVISED DATE: 8/28/15

PEER REVIEW

REVIEW:

- Good Samaritan Hospital and its medical staff are responsible for the quality of care provided to the patient population seen throughout the institution. Therefore, it is the policy of Good Samaritan Hospital to support the medical staff peer review process. The peer review process is a non-biased activity performed by the medical staff to measure, assess and, where necessary, improve performance on an organization wide basis.

PEER REVIEW PROGRAM COMPONENTS:

- The peer review process performed by the medical staff contains the following components:
 - Definitions of circumstances that may require peer review are listed below. This list can be revised at any time, as deemed appropriate by the Performance Improvement and Credentialing Committees of the medical staff. Revisions to the list must meet approval of *both* the Performance Improvement and Credentialing Committees, with final approval granted by the Medical Executive Committee. Circumstances requiring peer review include:
 - Unexpected deaths, deaths within 24 hours of hospital admission, postoperative death and/or any other type of patient death defined through the medical staff committee process and approved for review
 - Unexpected complications in patient condition and/or care or treatment, including those that result in major permanent loss of function, not related to the natural course of the patient's illness or underlying condition
 - Anticipated complications defined through the medical staff committee process and approved for review (such as CHF after patient MI)
 - Postoperative complications as defined by the Surgical Services Committee
 - Moderate to severe adverse drug reactions
 - All transfusion reactions (hemolytic, febrile, allergic)

- Patient suicide
 - Patient complaints and/or grievances against a medical staff member or members and those patient complaints or grievances related to medical staff management of care rendered
 - Staff complaints, grievances or concerns against a medical staff member or members related to the management of patient care
 - Utilization issues (delay of discharge, prolonged LOS, unsafe transfer or discharge of patient related to clinical stability, etc.)
 - Iatrogenic events
 - Appropriate use of blood and blood components
 - Appropriate use of medications
 - Appropriate use of nutritional products
 - Appropriateness, timeliness, completion and legibility of medical record content
 - Service specific defined performance indicators, as established and approved by the specific medical staff service committee and/or the Performance Improvement Committee
- Peer review process participants:
 - For the purposes of the peer review program, a peer reviewer shall be defined as a member of the medical staff, in good standing, licensed in the same medical specialty as the individual whose case is under review. Opinions from other medical staff peers (members in good standing on the medical staff, not licensed in the same specialty as the individual whose case is under review) may be offered and considered, regarding specific issues related to the management of the case under review - if these individuals are members of the reviewing committee (either standing or requested, ad-hoc committee members). Examples of peers that may offer opinions regarding medical management on a specific case include: an internist who sits as a regular member on the surgical services committee, a radiologist that sits as a regular member of the internal medicine committee, etc.
 - An individual functioning as a peer reviewer will not be in partnership with the individual whose case is under review.
 - An individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, *opinions* and *information* may be obtained from participants that were involved in the patient's care.
 - Selection of peer review panels for specific circumstances:

- Peer review panels may be selected in certain circumstances when additional consideration is necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.
- Peer review activity time frames:
 - Cases forwarded to medical staff committees for peer review are to be reviewed within one week of referral if possible.
 - Cases are identified for review through retrospective record review that is performed on an ongoing basis upon completion of medical record coding and record completion.
 - Cases are identified on a concurrent basis during routine quality and utilization review activities. Those cases requiring immediate action in the opinion of the first level nurse reviewer and them will be referred to the physician advisor for review. Cases determined to require immediate committee review by the physician advisor will be referred to the appropriate medical staff committee within the month or quarter that the medical staff committee is to meet. Cases determined by the physician advisor not to require immediate review will undergo the medical record completion process prior to referral to committee, but at no time shall referral be greater than a month time period from issue identification to medical staff committee peer review.
- Circumstances requiring external peer review:
 - Circumstances that require external peer review include, but may not be limited to:
 - ◆ Need for specialty review, when there are no medical staff members of the institution with the identified specialty within the organization;
 - ◆ The peer review committee cannot make a determination and requests external review;
 - ◆ The individual whose case is under review requests external peer review;
 - ◆ The Performance Improvement, Credentialing and/or Medical Executive Committees request external review.
- Participation in the peer review process by the practitioner whose performance is under review:
 - The individual whose case is under review has the right to present his or her information regarding case management to the committee performing peer review. The individual whose case is under review has the right to sit on the peer review committee during the time the case is reviewed and discussed, to provide additional information to the individuals performing peer review as necessary.
 - All individuals whose cases are referred for committee peer review shall be notified of the medical record number and date of admission of the case to be reviewed, in addition to the reason for review, at least two weeks prior to the scheduled peer

review meeting date. In cases of immediate referral to committee, as determined by the physician advisor, the physician advisor shall notify the individual whose case is under review, regarding the reason for review and the scheduled date of review, as soon as the physician advisor makes the determination that the case must be referred for formal peer review.

PEER REVIEW PROGRAM METHODOLOGY:

- To provide for an effectively functioning peer review process, the following program methodology will be conducted:
 - The peer review program is consistent - all cases referred for peer review shall follow the peer review program components listed above.
 - Time frames are adhered to in a reasonable fashion. All cases referred for peer review shall be reviewed within the time frames as listed above. In those instances where peer review falls out of the required time frames (medical record incomplete, practitioner under review is unavailable, reviewing committee rescheduling, etc.) the reasons for the delay will be documented in the medical staff committee minutes of the reviewing committee. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.
 - Conclusions of review are defensible. All cases undergoing peer review will have a worksheet completed that lists the rationale for the conclusion made by the peer reviewer(s). Rationale must be based on the reason the case was reviewed, and supported by current clinical practice, practice guidelines and/or literature.
 - Peer review is balanced. All opinions regarding medical management, including minority opinions, of the case under review will be considered in the ultimate determination of the case. This includes information and opinions from the individual whose case is under review.
 - Results of peer review are utilized at time of medical staff reappointment and to improve the organization's performance in individual situations, and, as a whole:
 - Results of peer review activities are aggregated and reported at time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges. A practitioner specific performance profile is completed and forwarded to the Credentialing Committee prior to medical staff member reappointment.
 - The peer review program is an ongoing component of the hospital wide performance improvement program and a routine component of each medical staff service committee.
 - Peer review conclusions, outcomes and actions resulting from peer review are monitored for effectiveness. Results of follow-up effectiveness monitoring are reported to the Performance Improvement Committee on a quarterly basis.



TITLE: PERMISSION TO OPERATE	SEARCH WORD: Permission to Operate
DEPARTMENT:	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

PERMISSION TO OPERATE

- There must be no doubt in the patient's mind as to who is to perform the operation. The permit (consent) for the operation must clearly establish to whom the patient gives this authority. In every instance, the surgeon(s) who performs the operation will be listed on the operative record as the surgeon and not the assistant. The surgeon is responsible for a proper informed consent being obtained from the patient and/or family, whichever is appropriate and for compliance with state and federal laws as applicable. The permit for operation must be ordered by the physician and signed before the operation. If multiple procedures are being considered, each procedure must be listed on the permit. The permit is to be completed and signed by the patient and person witnessing the signature before the patient is given any sedation or narcotic. The witness to the signature is to sign the permit, in the presence of the patient, or the individual giving permission for the operation. The exact time and date the permit is signed is to be recorded. A parent or a legal guardian must sign the permit for operation on any mentally incompetent patient or minor.
- When circumstances warrant an operation and there is no one to sign the permit for the operation, the surgeon and a consultant may take complete responsibility for the procedure by documentation in progress notes. This documentation is to specify why the procedure is necessary and that to delay, or not to perform the procedure, would be detrimental to the health and safety of the patient. It is recommended that two (2) physicians document this in the medical record of the patient.



TITLE: PHARMACY AND THERAPEUTICS COMMITTEE	SEARCH WORD: Pharmacy and Therapeutics Committee
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	REVISED DATE: 8/28/2015

PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee represents the liaison between the medical staff and the Pharmacy. The committee assists in formulating board professional policies relating to drugs in the hospital, including their evaluation, selection, procurement, storage, distribution, use and safety procedures. The committee is also responsible for developing a Formulary of Accepted Drugs for Good Samaritan Hospital and to provide for its periodic revision. Drugs used shall be those listed in the United States Pharmacopoeia, National Formulary and other drugs approved by the Pharmacy and Therapeutics Committee. As far as possible, the use of proprietary names shall be avoided and standard generic names employed.

FORMULARY SYSTEM:

- All drugs and medications administered to patients shall be those listed in the hospital formulary.
- Official drugs listed in the Unites States Pharmacopoeia and the National Formulary and new drugs approved for use by the Food and Drug Administration are eligible for consideration by the Pharmacy and Therapeutics Committee unless precluded by one of the following restrictions:
 - No drug will be admitted before its therapeutic value has been established.
 - No drug of secret composition will be admitted.
 - Mixtures of two (2) or more drugs will be admitted only if evidence is submitted that the mixture presents a significant therapeutic or practical advantage over the individual components singly administered.
 - No combinations will be accepted in which any therapeutic agent is present in a quality less than its usual therapeutic dose, unless the synergistic activity of the combination is sustainable.
- From drugs included in the hospital formulary, the Pharmacy may dispense equivalent drugs of equal and identical therapeutic composition for those drugs ordered under trade or proprietary names.
 - Nothing in this policy shall be interpreted to preclude prerogative of the physician in the treatment of his/her patient.

- The Pharmacy shall be permitted to dispense drugs not yet accepted by the Pharmacy and Therapeutics Committee on special requests and in emergencies. Repeated requests for any such emergent drugs will be submitted for study by the committee.
- The formulary shall be kept current:
 - To keep the hospital formulary current, the Pharmacy and Therapeutics Committee shall meet four (4) times annually.
- Members of the medical staff may request consideration of a drug for inclusion in the formulary. Requests will be submitted on a form, which is provided by the Pharmacy.
- All drugs will be labeled by non-proprietary or official name and brand name equivalent if ordered by brand.
- Sample drugs brought into the hospital by physicians and/or patients are not to be dispensed or administered.
- The use of drug abbreviations is strongly discouraged.
- The use of foreign drugs that are not approved by the FDA for use in the United States is not allowed at St. Mary's Good Samaritan.

DRUGS BROUGHT INTO THE HOSPITAL BY PATIENTS:

- Medications shall not be left at the patient's bedside unless the prescriber so orders. Such bedside medications shall be kept in a cabinet, drawer or in possession of the patient. Drugs shall not be left at the bedside which are listed in Schedule 2, 3 and 4 of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended.
- Medications brought by or with the patient to the hospital shall not be administered to the patient unless all of the following conditions are met:
 - The patient's attending physician has ordered the drug and the order entered in the patient's medical record.
 - The medication container(s) is clearly and properly labeled.
 - The content of the container(s) has been examined and positively identified after arrival at the hospital by the hospital pharmacist.

TAKE HOME PRESCRIPTIONS:

- All discharge prescriptions are to be written on prescription blanks (not on the chart order) to enable the patient to have their prescriptions filled at his/her local pharmacy.

NARCOTICS:

In accordance with the federal and state laws, narcotic drugs may be prescribed only by a physician registered with the Department of Justice and who has secured a special BNDD registry number.

NEW ORDERS:

A telephone order by the physician may be made to the nurse for a medication order, which could be considered an immediate or "STAT" nature as defined by the physician.

RENEWAL ORDERS:

- All orders prescribing drugs in the following categories must be renewed after 72 hours (3 days) unless they are ordered for a given period of time or a specific number of doses.
 - Narcotic Hypnotic:
 - This will include all DEA Class 2, 3 and 4 controlled drugs including but not limited to:
 - ◆ Chloral Hydrate
 - ◆ Codeine
 - ◆ Tylenol with Codeine
 - ◆ Dalmane
 - ◆ Demerol
 - ◆ Dilaudid
 - ◆ Morphine
 - ◆ Nembutal
 - ◆ Percodan
 - ◆ Seconal
 - ◆ Valium
 - Amphetamines - (Stimulants - CNS):
 - Dexedrine
 - Ritalin

- All orders in the following categories must be renewed after three (3) days unless the specific requirements are present:
 - Anticoagulants:
 - Heparin, Coumadin, Dicumarol unless daily coagulation studied (PTT) Protimes are also ordered
 - Nephrotoxic and Ototoxic:
 - Gentamicin, Tobramycin, Amikacin (or other new aminoglycosides) unless appropriate renal function tests are also ordered. It is suggested that serum, creatinine be done at least every other day. (Except appropriate test the 7-day renewal applies)
- All orders prescribing antibiotics (except as above) must be renewed after ten (10) days unless ordered for a specific number of doses or specific number of days.
- All orders for the above categories of drugs will be automatically discontinued 24 hours after stop order times, if new orders or renewal is written for the specific mentioned drugs.
- The nurse in charge of medications or the pharmacist will note on the chart three doses or 14 hours prior to “Stop Order Time”.

PHARMACIST CONSULTATIONS:

Upon request by a physician, hospital pharmacists will determine the appropriate dosage for certain medications in accordance with established protocols, which have been approved by the Pharmacy and Therapeutics Committee.



TITLE: PHYSICIAN ASSISTANTS / NURSE PRACTITIONERS	SEARCH WORD: Physician Assistants / Nurse Practitioners
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

PHYSICIAN ASSISTANTS / NURSE PRACTITIONERS

:

Persons certified by the Medical Board of Georgia State as physician assistants/nurse practitioners, shall have the right to perform only such professional duties or acts within Good Samaritan Hospital as are specifically authorized by the Medical Executive Committee. Every physician assistant shall, by requirement of hospital, make application to, and be approved (or disapproved) by the departmental committee, the Medical Staff Committee and the Governing Body.

APPLICATION TO PRACTICE - CONTENT:

- Before making any recommendation granting any rights to such persons, the appropriate departmental committee shall be provided with a sufficiently completed application which will establish to its satisfaction, at least the following:
 - The applicant is certified and in good standing as a physician assistant/nurse practitioner, pursuant to the laws of the State of Georgia.
 - The scope of practice proposed to be carried out by the applicant is within the scope of such practice authorized by the Medical Board of Georgia.
 - That the educational qualifications and experience of the applicant are consistent with the required duties.
 - The name of the applicant's supervising physician who shall be responsible for his/her supervision.

STATEMENT BY SUPERVISING PHYSICIAN:

- *In addition to the required application referenced above, a written request signed by the applicant's supervising physician shall be submitted specifying those duties and acts which the applicant shall be authorized to perform within the hospital. Each such request shall include a statement by said physician, together with necessary additional documentation to establish the following:*

- That the supervising physician accepts full legal and ethical responsibility for the performance of all approved duties and acts.
- What entries by way of observation or transcription, the supervising physician proposes to allow to be entered upon the patient's chart by the physician assistant.
- Those specific duties and acts, including histories and physical examinations, that the supervising physician requests the applicant be permitted to perform outside of his immediate supervision and control.
- That the applicant is covered by the employer's professional liability policy and the acceptable limits thereof. This fact shall be established by a verification of such coverage in a form acceptable to the committees.
- Proof that the supervising physician has obtained approval to supervise the physician assistant from the Medical Board of Georgia in the type and scope of practice for which applied.
- A clear delineation of the authority if any, that such physician assistant may have as related to hospital personnel.

STATEMENT OF DUTIES OF SUPERVISING PHYSICIAN:

- The supervising physician shall also sign a statement in a form to be approved by the Medical Executive Committee which shall indicate his/her willingness to honor the following statements:
 - Agreement that he/she will immediately notify the Medical Executive Committee in writing, in the event his/her approval to supervise the applicant is revoked, limited or otherwise altered by action of the Medical Board of Georgia, or in the event of any notification of investigation of his supervision of the applicant by the Board, or if there is a change in the employment status of the physician assistant/nurse practitioner.
 - Agreement to inform all patients of the procedures to be performed by the applicant physician assistant/nurse practitioner, identified as such, and to obtain written informed consent for surgical procedures as required by the regulations of the Medical Board of Georgia and in accordance with such rules and regulations of the Medical Board of Georgia, and rules and regulations pertaining thereto, of St. Mary's Good Samaritan.
 - Agreement to comply with all regulations of the Medical Board of Georgia and the hospital, with respect to his/her supervision of the applicant physician assistant/nurse practitioner specifically including (but not limited to) such regulations as have been (or may be) adopted by said Board and Hospital and the Medical Executive Committee, with respect to billing for the services of such physician assistant; requirements for supervision of said physician assistants /nurse practitioner with respect to the type and scope of services such physician assistant is approved to perform by the Board; and requirements for identification of the physician assistant/nurse practitioner while rendering medical services. It shall be understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by the Medical Executive Committee of the performance of services by a physician assistant/nurse practitioner in the hospital.

PRACTICE CONTINGENT OF STAFF STATUS OF SUPERVISING PHYSICIAN:

The right of a physician assistant/nurse practitioner to render medical services within the hospital shall be contingent upon the supervising physician's continued membership on the medical staff. If the supervising physician terminates his/her staff membership, or if this membership is suspended or revoked, the physician assistant's/nurse practitioner's privileges shall automatically be terminated.

DISCIPLINARY ACTION:

After consultation with the supervising physician, any approval of a physician assistant/nurse practitioner pursuant to this section may be modified or terminated by the Medical Executive Committee at any time or upon recommendation of the Department Chairperson. The Medical Executive Committee shall promptly advise the physician assistant and the supervising physician of any such suspension or restriction and grounds for such action. Any individual that has been granted clinical privileges, however is not a member of the medical staff has the right to a fair hearing and appeal process.

FAIR HEARING:

Any individual that has been granted clinical privileges, but is not a member of the medical staff has a right to a fair hearing and appeal process. In the event that the activities of a physician assistant/nurse practitioner are denied, suspended, restricted or limited, the supervising physician may, within five (5) days of the receipt of notice of such action, request an interview before the Medical Staff. This meeting shall be held promptly. Both the supervising physician and the physician assistant/nurse practitioner shall be given at least three (3) days notice of the time and place of the interview. The interview shall be conducted informally as a professional discussion without the participation of legal counsel or application of the technical rules of evidence. The decision of the Medical Staff shall be final as to all substantive matters.

ANNUAL REVIEW:

An annual review of physician assistants/nurse practitioner shall be conducted by the Medical Staff.

DUTIES AND RESPONSIBILITIES:

- **Surgery Section:**

Members of the Surgery Physician Assistant/NURSE PRACTITIONER Program may:

- Take histories and perform physical examinations upon hospital patients.
- Record pertinent data from histories and physical examinations on forms provided by the hospital; such reports shall be reviewed and countersigned by a supervising physician within 24 hours.
- Initiate orders for medications and other therapy, which shall be submitted for approval of the supervising physician prior to their being carried out; record pertinent patient data on the medical record; prepare a summary of hospitalization. All such entries in the patient's record shall be countersigned within 24 hours by the supervising physician.

- Initiate orders for laboratory and x-ray tests.
- Perform the following procedures:
 - Injections
 - Perform venipunctures both to obtain samples and to start intravenous fluids
 - Debridement, suture and care of superficial wounds
 - Removal of sutures
 - Subcutaneous local anesthesia, excluding any nerve blocks
 - Incision and drainage of superficial skin infections
 - Insert intravenous needles and catheters and administer intravenous medication upon the order of a supervising physician
 - Perform intubation of airway in emergency situations
 - Recognize and evaluate (or evaluate and respond to) situations which call for immediate attention of the attending physician and institute, when necessary, treatment procedures essential for the life of the patient
 - Apply all types of wound dressings
 - Insert peripheral venous and perform cutdowns on arteries and veins
 - Perform cardiopulmonary resuscitation and defibrillation of the heart
 - Perform electrocardiograms and suggest tentative interpretation of EKG strips
- Assist the surgeon in the hospital setting by arranging hospital admission, by providing service to patients requiring continuing care, including the review of treatment and therapy plans, and by evaluating patients and performing the procedures and specified tasks.
- Facilitate the surgeon's referral of patients to the appropriate health facilities, agencies and resources of the community.
- Perform such duties during the surgery of the patients as directed by the supervising physician and documented by training and experience.
- Close any or all dermal structures.
- Remove chest tubes.
- Work in the care units, help in the operative and postoperative management of those patients as specified in the above duties and responsibilities.



TITLE: POLICY ON PRACTITIONER HEALTH ISSUES	SEARCH WORD: Health
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

POLICY ON PRACTITIONER HEALTH ISSUES

Because practitioner health issues include a variety of problems from substance abuse to physical or mental illness, all steps outlined in this Policy may not be suitable in every circumstance. For example, when the impairment is due to age, irreversible medical illness, or other factors not subject to rehabilitation, the sections of the Policy dealing with rehabilitation and reinstatement of the physician are not applicable.

The authorization and release forms attached as appendices to this Policy are designed to be HIPAA-compliant and should be used together.

POLICY STATEMENT:

1. The Hospital and its Medical Staff are committed to providing quality care, which can be compromised if a member of the Medical Staff is suffering from an impairment.
2. "Impairment" means substance abuse or a physical, mental or emotional condition that adversely affects an individual's ability to practice safely and competently.
3. The Practitioner Health Committee¹ shall recommend to the Executive Committee educational materials that address Practitioner Health issues and emphasize prevention, diagnosis, and treatment of physical, psychiatric, and emotional illness.
4. To the extent possible, and consistent with quality of care concerns, the Practitioner Health Committee will handle impairment matters in a confidential fashion. The Practitioner Health Committee shall keep the Chairperson of the Credentials Committee apprised of matters under review.

MECHANISM FOR REPORTING AND REVIEWING POTENTIAL HEALTH CONCERNS

5. Practitioners who are suffering from an impairment are encouraged to voluntarily bring the issue to the Practitioner Health Committee so that appropriate steps can be taken to protect patients and to help the physician to practice safely and competently.
6. Any individual who is concerned that a member of the Medical Staff is impaired shall submit a written report to the Medical Director factually describing the incident(s) that led to the concern.

¹ Practitioner Health Committee (PHC) shall be composed of the Medical Director, the President of the Hospital or designee, the Department Chief of the involved individual. The Medical Director or the Department Chief of the individual involved may serve as chair or their designee.

7. If, after discussing the incident(s) with the individual who filed the report, the Medical Director believes there is enough information to warrant a review, the matter shall be referred to the Practitioner Health Committee.
8. The Medical Director shall inform the individual who filed the report that follow-up action was taken, however, the specifics of any action shall not be shared in light of their confidential nature.

CONCERNS REQUIRING AN IMMEDIATE RESPONSE

9. Any individual who is concerned that a member of the Medical Staff who is on Hospital premises is impaired and poses an immediate threat to the health and safety of patients or to the orderly operation of the Hospital, shall immediately notify the relevant department chairperson, the Medical Director, or their designees.
10. The department chairperson and Medical Director (or their designees) shall immediately assess the physician and, if necessary to protect patients, may relieve the physician of patient care responsibilities. In that situation, the affected physician's hospitalized patients may be assigned to another individual with appropriate clinical privileges or to the appropriate physician on call. The wishes of the patient(s) shall be considered in the selection of a covering physician. The affected patients shall be informed that their physician is unable to proceed with their care due to illness.
11. Following the immediate response, the department chairperson and Medical Director (or their designees) shall file formal reports as described in this Policy, in order for the question of impairment to be more fully assessed and addressed by the Practitioner Health Committee.

REVIEW BY PRACTITIONER HEALTH COMMITTEE

12. The Practitioner Health Committee shall act expeditiously in reviewing concerns of potential impairment. As part of its review, the Practitioner Health Committee may meet with the individual(s) who filed the initial report.
13. If the Practitioner Health Committee believes that the physician is or might be impaired, it shall meet with the physician. At this meeting, the physician should be told that there is a concern that he or she might be suffering from an impairment and advised of the nature of the concern, but should not be told who filed the initial report.
14. The Practitioner Health Committee may request that the physician be evaluated by an outside physician or organization and have the results of the evaluation provided to it. A form authorizing the Hospital to release information to the outside physician or organization conducting the evaluation is attached as Appendix A. A form authorizing the outside physician or organization to disclose information about the physician to the Practitioner Health Committee is attached as Appendix B.

PRACTITIONER HEALTH COMMITTEE RECOMMENDATIONS

15. Based on the severity and nature of the impairment, the Practitioner Health Committee may recommend to the physician that he or she:
 - a. take a voluntary leave of absence to participate in a rehabilitation program or receive medical treatment; or
 - b. voluntarily refrain from exercising some or all privileges until an accommodation can be made to ensure that the physician is able to practice safely and competently; or
 - c. voluntarily agree to conditions or restrictions on his or her practice.

If the Practitioner Health Committee recommends that the physician participate in a rehabilitation or treatment program, it shall assist the physician in locating a suitable program.
16. If the physician does not agree to abide by the Practitioner Health Committee's recommendations, the matter shall be referred to the Executive Committee for an investigation to be conducted pursuant to the Credentials Policy.
17. If the physician agrees to abide by the recommendations of the Practitioner Health Committee, a confidential report will be made to the applicable department chairperson and the Chairperson of the Credentials Committee. In the event either of these individuals is concerned that the action of the Practitioner Health Committee is not sufficient to protect patients, the matter will be referred back to the Practitioner Health Committee with specific recommendations on how to revise the action or it will be referred to the Executive Committee.

REINSTATEMENT/RESUMPTION OF PRACTICE

18. Upon sufficient proof that a physician has successfully completed a rehabilitation or treatment program, the Practitioner Health Committee may recommend to the Executive Committee and the Board that the physician's clinical privileges be reinstated. In making such a recommendation, patient care interests shall be paramount.
19. Prior to recommending reinstatement, the Practitioner Health Committee must obtain a letter from the physician overseeing the rehabilitation or treatment program. (A form authorizing this letter is attached as Appendix B.) The letter must address the following:
 - a. the nature of the physician's condition;
 - b. whether the physician is participating in a rehabilitation program or treatment plan and a description of the program or plan;
 - c. whether the physician is in compliance with all of the terms of the program or treatment plan;
 - d. to what extent the physician's behavior and conduct need to be monitored;
 - e. whether the physician is rehabilitated or has completed treatment;
 - f. whether, if applicable, an after-care program has been recommended to the physician and, if so, a description of the after-care program; and
 - g. whether the physician is capable of resuming medical practice and providing continuous, competent care to patients.
20. Before recommending reinstatement, the Practitioner Health Committee may request a second opinion on the above issues from the physician of its choice.

21. Assuming that all of the information received indicates that the physician is capable of safely resuming care of patients, the following additional precautions shall be taken before the physician's clinical privileges are reinstated:
 - a. the physician must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the physician's inability or unavailability; and
 - b. the physician shall be required to provide periodic reports to the Practitioner Health Committee from his or her attending physician or other treating professionals, for a period of time specified by the Committee, stating that the physician is continuing rehabilitation or treatment, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired. Additional conditions may also be recommended for the physician's reinstatement.
22. If the physician has taken a formal leave of absence, the final decision to reinstate a physician's clinical privileges must be approved pursuant to the process set forth in the Credentials Policy.
23. The physician's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be recommended by the Practitioner Health Committee in consultation with the department chairperson.
24. If the impairment is related to substance abuse, the physician must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the Medical Director, the Chairperson of the Credentials Committee, or any member of the Practitioner Health Committee.
25. In the event of any apparent or actual conflict between this Policy and the bylaws, rules and regulations, or other policies of the Hospital or its Medical Staff, including the investigation and hearing and appeal sections of those bylaws and policies, the provisions of this Policy shall control.

DOCUMENTATION AND CONFIDENTIALITY

26. The original report and a description of any recommendations made by the Practitioner Health Committee shall be included in the physician's credentials file. If, however, the review reveals that there was no merit to the original report, the report will not be accepted for the file. If the review reveals that there may be some merit to the report, but does not rise to the level of seriousness to require immediate action, the report shall be included in the physician's credentials file and the physician's activities and practice shall be monitored until it can be established whether there is an impairment that might affect the physician's practice. The physician shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her credentials file.
27. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.
28. If at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the physician or others, the Hospital Administration or the President of the Medical Staff may contact law enforcement authorities or other governmental agencies. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq., and the Georgia Peer Review Protection Act, or the corresponding provisions of any subsequent

federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the Hospital and its Board of Directors when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

29. All requests for information concerning the impaired physician shall be forwarded to the Medical Director for response.
30. Nothing in this Policy precludes immediate referral to the Executive Committee or the elimination of any particular step in the Policy in dealing with conduct that may compromise patient care.

Approved by the Medical Executive Committee this _____ day of _____, 20__.

Medical Director

APPENDIX A
CONSENT FOR DISCLOSURE OF INFORMATION
AND
RELEASE FROM LIABILITY

I hereby authorize St. Mary's Hospital (the "Hospital") to provide _____
[facility performing health assessment] (the "Facility") all information, both written and oral, relevant to an
evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow the Facility to conduct a full
and complete evaluation of my health status so that the Hospital can determine if I am able to care for
patients safely and competently.

I also understand that the information being disclosed is protected by the Georgia peer review law and
that the Hospital, the Facility, and others involved in the peer review process are required to maintain the
confidentiality of peer review information, pursuant to that state law.

I release from any and all liability, and agree not to sue, the Hospital, or any of its officers, directors,
employees or any physician on the Hospital's Medical Staff, or any authorized representative of the
Hospital, for any matter arising out of the release of information by the Hospital to the Facility.

I also release from any and all liability, and agree not to sue, the Facility, or any of its officers, directors,
employees or authorized representatives, for any matter arising out of the Facility's provision of an
evaluation of my health status to the Hospital.

Date

Signature of Physician

APPENDIX B

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

I hereby authorize [facility performing health assessment and/or practitioner overseeing treatment or treatment program] (the "Facility") to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice, to St. Mary's Hospital (the "Hospital") and its Medical Executive Committee or Practitioner Health Committee. The information to be released includes, but is not limited to, answers to the questions on the attached Health Status Assessment Form, along with the following:

- (a) the nature of my condition;
- (b) whether I am participating in a rehabilitation program or treatment plan;
- (c) whether I am in compliance with all of the terms of the program or plan;
- (d) to what extent my behavior and/or conduct needs to be monitored;
- (e) whether I am rehabilitated or have completed treatment;
- (f) whether, if applicable, an after-care program has been recommended for me and, if so, a description of the after-care program; and
- (g) whether I am capable of resuming medical practice and providing continuous, competent care to patients.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for medical staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

I understand that the willingness of the Facility to conduct this assessment or provide treatment does not depend on my signing this Authorization.

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Since the Hospital is paying for the health assessment and/or treatment and since the Hospital has conditioned payment for the assessment and/or treatment on receipt of a report, the Facility may refuse to conduct the assessment or provide treatment if I refuse to sign this Authorization.

I understand that my health information is protected by federal law and that, by signing this Authorization, the information will be disclosed to the parties hereby authorized to receive it and could be disclosed to other parties. However, I also understand that the information being disclosed is protected by state peer review laws and that the Facility, the Hospital, and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to those state laws.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Facility has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when the Facility has knowledge of it.

This Authorization expires when my medical staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Facility may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date
Physician

Signature of

APPENDIX C

HEALTH STATUS ASSESSMENT

CONFIDENTIAL PEER REVIEW DOCUMENT

HEALTH STATUS ASSESSMENT

Please respond to the following questions based upon your assessment of Dr. _____'s current health status (if additional space is required, please attach separate sheet):

1. Does Dr. _____ have any physical, psychiatric, or emotional condition that could affect his/her ability safely to exercise the clinical privileges set forth on the attached list and/or perform the duties of appointment, including response to emergency call? _____ Yes No

If yes, please provide the diagnosis/diagnoses and prognosis: _____

2. Is Dr. _____, _____, _____ currently taking any medication that may affect either clinical judgment or motor skills? Yes No

If yes, please specify medications and any side effects: _____

3. Is Dr. _____, _____ currently under any limitations concerning activities or work load? Yes No

If yes, please specify: _____

4. Is Dr. _____ currently under the care of a physician? _____ Yes No

If yes, please identify: _____

5. In your opinion, is any accommodation necessary to permit Dr. _____ to exercise privileges safely and/or to fulfill medical staff responsibilities appropriately? Yes No

If yes, please explain any such accommodation: _____

Date

Signature of Physician Evaluator

TITLE: RESTRAINTS	SEARCH WORD: Restraints
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

RESTRAINTS

- An order by a MD or DO is required for the application of physical restraints. The order must specify:
 - The type of device
 - The length of time for restraint (no PRN orders)
 - Clinical justification
 - Date and time
 - That alternative measures were attempted/considered and were felt to be unsatisfactory
- Restraint orders must be assessed for appropriateness by a face-to-face interaction by the practitioner at least once every 24 hours and an order rewritten, if necessary.
- Telephone orders for emergency implementation must be signed by the practitioner within 24 hours. Emergency orders may be implemented by the nurse, but the order must be validated by the physician, pursuant to the organizational policy on restraint and seclusion.



TITLE: SCHEDULING OF PROCEDURES	SEARCH WORD: Procedures
DEPARTMENT:	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

SCHEDULING OF PROCEDURES

- Reservations are made by calling the individual department (Operating Room, GI Lab, X-ray or Cardiac Catheterization Lab) who in turn will notify the Centralized Scheduling Department for room reservation. Transfusions are scheduled directly with Centralized Scheduling.
- The attending physician will provide orders to the Pre-anesthesia Unit prior to the patient's admission. Orders may be written, faxed to or given over the telephone to the Pre-anesthesia Unit.
- The attending physician must provide pre-procedure instructions to the patient. The standardized pre-procedure form is recommended.
- The attending physician must clear for discharge all cardiac catheterization patients following the procedure.
- The attending physician should document discharge instructions on the appropriate form on the chart.



TITLE: SPECIAL TREATMENT SERVICES	SEARCH WORD: Special Treatment
DEPARTMENT: MEDICAL STAFF	
PRESIDENT APPROVAL:	MEDICAL DIRECTOR APPROVAL:
EFFECTIVE DATE:	UPDATED: 8/28/15

SPECIAL TREATMENT SERVICES

- Treatment Procedures That Require Special Justification:
 - All physicians must comply fully with the physical restraint and/or seclusion policy for a specific patient care setting.
 - Electroconvulsive therapy is not performed in this facility.
 - Psychosurgery is not performed in this facility.
 - Behavior modification procedures that use aversive conditioning are not performed in this facility.

SPECIAL TREATMENT PROCEDURES:

- *Protective Security:*
 - Combative/Confused Patients:
 - It is the responsibility of the clinical staff to respond to any situation where a patient or other individual on a station is in imminent danger of harming himself or another person. This requires immediate clinical assessment and/or intervention, which may include restraint and/or seclusion.
 - *Restraint and Seclusion:*
 - *Orders for restraint or seclusion will specify the type of restraint or seclusion, the specific reason for restraint/seclusion, and the duration of restraint/seclusion. Orders for leather restraints, four point restraints or seclusion may not exceed 24 hours. In no case may the duration of an order for restraint exceed 24 hours. In all cases, orders for restraint will comply with the guidelines set forth in the organizational policy on restraint and seclusion.*

- Emergency Commitment (Inpatients Who Require a Change of Status from Voluntary to Involuntary Admission):
 - A patient who becomes disturbed and seeks to leave the hospital may be detained as an involuntary patient for 72 hours, in accordance with state and federal law, if he/she is considered, due to mental illness, to be:
 - ◆ A danger to others,
 - ◆ A danger to him/herself, or
 - ◆ Gravely disabled (a condition in which a person is unable to provide for basic needs for food, clothing, or shelter).