Trinity Health System

MacNeal Hospital

Rules and Regulations

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ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and case management/utilization standards in effect in the Hospital.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short-term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with the Hospital's Patient Access Department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the attending practitioner or designee shall contact the Hospital's Patient Access Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

Admission/Registration personnel will admit/register patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission; however their condition is not life threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for their health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients greater than twenty

(20) weeks' gestation and with a pregnancy related complaint will be evaluated in Labor and Delivery per Hospital policy.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Pregnant patients, greater than twenty (20) weeks' gestation, with a primary obstetrical complaint can have their medical screening exam done in the obstetrics area. The Hospital policy is "EMTALA".

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

a. the patient does not have an established relationship with a practitioner, within the past three (3) years outside of that in an unassigned capacity, or does not indicate a preference;

b. the patient's established practitioner does not have admitting privileges; or

c. the patient's injuries or condition fall outside the scope of the patient's established practitioner.

2.2.2 Unassigned Call Service

a. **Unassigned Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Chair, or designee, shall provide the Medical Staff Office with a list of physicians who are scheduled to take emergency call on a rotating basis.

b. **Response Time**: It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame. The on-call physician, or designee, are expected to respond to calls from the Emergency Department within thirty (30) minutes by telephone, and are expected to arrive at the Hospital, if requested to see the patient, within one (1) hour unless a shorter timeframe is noted by specialty. If the on-call physician does not respond to being called or paged, the physician's Department Chair shall be contacted; if the Department Chair is unavailable the President of the Medical Staff shall be contacted; if the President of the Medical Staff is unavailable, the Chief Medical Officer shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call physician's responsibility to arrange for coverage and officially notify the Medical Staff Office if they are unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. If the Emergency Department physician and the consultant agree that the outpatient visit can serve in lieu of the consultant coming in to the Emergency Department, the consultant is obligated to see the patient in the office for at least one (1) visit, regardless of the patient's ability to pay.

If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant is required to come in to the Emergency Department to make appropriate arrangements.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department will be referred to the practitioner taking unassigned call that day unless a patient-physician relationship has been developed and the patient is no longer considered Unassigned.

2.2.5 Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

a. Unassigned call duties, to supply basic stabilization and disposition of the patient, should be based on the appointee's clinical core privileges even though specific items in the core may be deleted. Physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category; the Medical Executive Committee shall determine which specialties are required to have call schedules.

b. Unassigned call duties shall be assigned by the Department Chair (or designee), and approved by the MEC and Board for those specialties in which coverage is not available 24/7/365. A full call schedule is required if there are three (3) or more physicians in the specialty.

c. Exemptions to the ED call roster:

   i. When call is covered under a contractual obligation; and

   ii. Physicians can request an exemption from the ED on-call roster when they are at least sixty-five (65) years of age. Exemptions may be granted only if it does not create an uncovered period in the call schedule. If the exemption would create an uncovered period in the call schedule, please refer to Section 2.2.5.b above. It is noted that a physician may have his/her exemption rescinded if there is a shortage of physicians in the specialty creating uncovered call days.

d. Unassigned duties may be divided by department, specialty, or subspecialty.

e. Physicians on unassigned call may take call at more than one hospital simultaneously, as long as they have back-up coverage in case of emergencies occurring simultaneously at two different hospitals.

f. Physician may perform elective surgery while on unassigned call, as long as they have back-up coverage in case of emergencies that occur while performing elective procedures.

g. Physicians may serve in a community call plan, in accordance with EMTALA guidelines, for the provision of call in a specialty.

h. Physicians must be listed by name on the unassigned call list; they cannot be listed by group.

i. The ED practitioner must make the first communication regarding an unassigned patient to the physician on the unassigned call list when needed; they cannot call only an APP taking call for the physician on the initial call.

j. An impairment which is alleged to limit an appointee's ability to provide Unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

2.2.6 Use of the Unassigned Call Roster

The Unassigned call roster may be used as default consultation coverage when a practitioner cannot obtain consultation on a patient on a voluntary basis.

2.2.7 Failure to Meet Unassigned Call Obligations

All failures to meet Unassigned call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer;

b. The patient's condition must meet medical necessity criteria;

c. The patient must require, and this Hospital must be able to provide, a higher level of care or a specific inpatient service is not available at the transferring facility or that the patient or family requests the transfer;

d. Responsibility for the patient must be accepted by a physician with appropriate privileges at this Hospital; and

e. The transfer must be approved by the Hospital representative with authority for accepting transfers.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers.

2.3.3. Transfers to Another Hospital

Patients who are transferred to another hospital must follow the Hospital policy on transfers to ensure EMTALA compliance.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the hospital " Suicide Risk" policy.

2.5 PROMPT ASSESSMENT

All new admissions are expected to be personally assessed within the following timeframes:

- ICU admissions within one (1) hour
- Routine admissions within twenty-four (24) hours
- Behavioral health admission within twenty-four (24) hours

All new admissions will have a history and physical examination completed and on the record within twenty-four (24) hours.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or privileged designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

a. A list of all medications the patient is to take post-discharge;

b. Dietary instructions and modifications;

c. Medical equipment and supplies;

d. Instructions for pain management;

e. Any restrictions or modification of activity;

f. Follow up appointments and continuing care instructions;

g. How to seek emergent care if the patient's condition deteriorates;

h. Referrals to rehabilitation, physical therapy, and home health services; and

i. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice. Although no discharge order is necessary for patients who leave against medical advice, a discharge summary is required.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare providers will undergo appropriate EHR training, and comply with security guidelines.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.1.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record. These will include at a minimum:

- U for Units
- IU for International Units

- QD for Daily
- QOD for Every Other Day
- Trailing Zero (X.0)
- Always Use Leading Zero (0.X)
- MS or MSO4 for Morphine Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses, on informed consents, or on operative procedures.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions, all inpatient surgeries requiring anesthesia (general, regional, MAC, or deep sedation), and all observation patients. A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;

d. An age-appropriate social history;

e. A pertinent family history;

f. A review of systems;

g. Cardiorespiratory exams and other relevant physical findings;

h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

A focused history and physical examination or outpatient assessment, used for outpatient procedures including the use of anesthesia or moderate sedation, should include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, and current diagnoses;

d. Relevant physical findings, including an evaluation of the cardiac and respiratory systems and the affected body area;

e. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician, or designee.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Radiology Department and Catheterization Lab (angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiologic studies, and ablations); and

c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed. In cases of procedures performed by dentists, or podiatrists who may not have history and physical privileges, the pre-anesthesia evaluation may suffice for the update to the history and physical examination. This does not preclude the entry of an update note by the dentist, or podiatrist who may not have history and physical privileges.

3.7 PROGRESS NOTES

The attending service will record a progress note each day, and for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued

hospitalization. All patients in the intensive care units must be seen daily by a physician. Progress notes documented by APPs, residents, and fellows require co-signature within one (1) calendar day.

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery, and in no case later than twenty-four (24) hours after the end of the procedure, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Operative/procedure reports will include:

a. name and hospital identification number of the patient,

b. date and times of the surgery,

c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,

d. the pre-operative and post-operative diagnoses,

e. the name of the procedure performed,

f. a description of the procedure performed,

g. the type of anesthesia administered,

h. findings of the procedure,

i. complications, if any,

j. any estimated blood loss,

k. any specimen(s) removed, and

l. any prosthetic devices, transplants, grafts, or tissues implanted.

3.9 POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. This note needs to be finalized prior to transfer out of the Post Anesthesia Care Unit (PACU) or in an intensive care unit if the surgeon accompanies the patient to the intensive care unit. Operative/procedure notes will include:

a. the name of the surgeon(s) who performed the procedure and any assistants,

b. the name of the procedure performed,

c. findings of the procedure,

d. any estimated blood loss,

e. any specimen(s) removed,

f. type of anesthesia administered,

g. any complications, and

h. the pre-operative/procedure and post-operative/procedure diagnosis.

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS

3.10.1 Pre-anesthesia notes

Anesthesia is defined as general, regional, monitored anesthesia care (MAC), and deep sedation. A pre-anesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made by an individual qualified to administer anesthesia, the administration of anesthesia and entered into the medical record of each patient receiving anesthesia at any anesthetizing location and shall contain the following information:

a. A review of the medical history,

b. An interview and examination of the patient,

c. A documented airway assessment,

d. An anesthesia risk assessment,

e. An anesthesia, drug and allergy history,

f. Performed by an individual, qualified, and privileged to administer anesthesia/sedation, within 48 hours prior to inpatient or outpatient surgery or procedure requiring anesthesia services. (Delivery of the first dose of medications for the purpose of inducing anesthesia marks the end of the 48-hour time frame).

3.10.2 Pre-sedation assessments

Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner. The pre-sedation assessment shall follow the guidelines in the Loyola Medicine Moderate Sedation Policy and MacNeal Hospital Deep Sedation Policy.

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES

3.12.1 Post-anesthesia notes

A post-anesthesia evaluation shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving anesthesia or deep sedation. The note shall be entered by an anesthesia provider or by the physician who administered the deep sedation. This note should contain the following information:

a. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

b. Cardiovascular function, including pulse rate and blood pressure;

c. Mental status;

d. Temperature;

e. Pain;

f. Nausea and vomiting; and

g. Postoperative hydration.

3.12.2 Post-sedation notes

A post-sedation note shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving moderate sedation. The note shall contain follow the requirements in the Loyola Medicine Moderate Sedation Policy.

3.13 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report is expected to be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours after receipt of notification of the consult request. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. If a consultation is performed by a non-physician, the consulting physician must cosign the consultation or enter their own note.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record if available, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete and the last prenatal visit was within thirty (30) days of admission. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the bylaws will be documented.

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. The discharge summary should be completed within seven (7) days after discharge. All discharge summaries are the responsibility of the discharging physician on the day of discharge, or privileged designee.

a. **Content**: A discharge summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the discharging physician and will contain:

   1. Reason for hospitalization;
   2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
   3. Condition of the patient at discharge;
   4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
   5. Final diagnoses.

b. **Short-term Stays**: A discharge summary is not required for uncomplicated inpatient and observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician, or designee, enters a final progress note or completes a Discharge Form documenting:

   1. The condition of the patient at discharge; and
   2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A discharge summary is required on all inpatients who have expired and will include:

   1. Reason for admission;
   2. Summary of hospital course; and
   3. Final diagnoses.

d. **Timing**: A Discharge Summary is encouraged to be entered and signed in the medical record within twenty-four (24) hours after discharge, transfer, or death.

Any discharge summary used for readmission purposes must be completed within one (1) day.

3.17 DIAGNOSTIC REPORTS

Diagnostic reports must be read and reported within timeframes defined in the Loyola Medicine Critical Radiology Results Reporting Policy.

3.18 ADVANCED PRACTICE PROFESSIONALS

No Advanced Practice Professional may order chemotherapy or radiation therapy.

3.18.1 Cosignature Requirements for APPs Granted Privileges Without Supervision

Nurse Practitioners and Physician Assistants who are granted privileges without supervision need only have their operative notes, admission orders, and discharge summaries cosigned by a collaborating/supervising physician. Certified Nurse Midwives granted privileges without supervision requires only their discharge summaries to be cosigned by a collaborating/supervising physician.

3.18.2 Cosignature Requirements for APPs Granted Privileges With Supervision

Physician Assistants (PAs), Certified Nurse Midwives (CNMs), and Nurse Practitioners (NPs are required to have all their documentation cosigned as noted below. The timeframes for these cosignatures are:

a. The collaborating/supervising physician will either enter their own note or attest to the APP's note, within one (1) calendar day, for all history and physical examinations;
b. The collaborating/supervising physician will either enter their own note or attest to the APP's note, within one (1) calendar day, for all consultations;
c. The collaborating/supervising physician will either enter their own note or attest to any progress notes performed by APPs within one (1) calendar day.
d. Routine orders of an Advanced Practice Registered Nurse (APRN) do not need cosignature by a physician except for orders for:
   i. controlled substances when the APRN does not have their own independent DEA number; and
   ii. admission orders if the APP does not have admitting privileges themselves;
e. Routine orders of a PA require cosignature within one (1) calendar day;
f. The collaborating/supervising physician will review and authenticate all discharge summaries prepared by all Advanced Practice Professionals.

3.19 STUDENTS, RESIDENTS AND FELLOWS IN TRAINING

Students, and residents and fellows in training, who are not moonlighting outside of their training program, must have their:

a. History and physical examinations, progress notes, operative notes, operative reports, and discharge summaries cosigned within one (1) calendar day by the attending physician, or their physician designee;
b. Orders of the resident or fellow do not need to be cosigned with the exception of the admission order and chemotherapy orders;

Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Designated Institutional Officer, or designee, in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

3.20 PROVIDER-BASED CLINICS

In provider-based clinics, all office notes must be completed within three (3) days of the visit. A problem list (medications, allergies, and chronic illnesses) must be completed by the end of the first visit.

3.21 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, personal health information (PHI) contained in the record will be made available to any member of the Medical Staff attending the patient, to members of medical staffs of other hospitals, and to others in accordance with HIPAA. Records must be retained pursuant to the Loyola Medicine Retention Medical Records and Source Data Policy.

a. **Access to Old Records**: In case of readmission of a patient, all records still maintained will be available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized transmission or deletion of medical records from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to PHI from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.22 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the MEC.

3.22.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the Trinity Health System "Medical Records Delinquency Policy."

3.22.2 Policy on Incomplete Records

The MacNeal Hospital Non Admit List Epic Policy define the parameters of action to be taken on practitioners with medical records delinquencies.

3.23 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.24 CUT AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter. "Cut and Paste" or "Copy and Paste" of entries in the Medical Record that are not updated with current information is prohibited. The Hospital requires that its practitioners accurately and concisely document the services provided and information gathered during each patient encounter, regardless of whether or not health information is generated electronically or manually entered. Please see the LUHS Copy and Paste Functionality in Electronic Patient Records Policy.

3.25 ORGANIZED HEALTH CARE ARRANGEMENT

a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA"), the Medical Staff of MacNeal Hospital are deemed to be members of, and a part of, an *Organized Health Care Arrangement* ("OHCA") as that term is defined within HIPAA. This designation is required to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a "clinically integrated care setting." As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with the Hospital and the hospital's medical staff. No member shall be liable for any actions, inactions, or liabilities of any other member. Each member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

b. The members hereby adopt the Hospital Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the joint Notice of Privacy Practices.

c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any

protected health information, or has access to any Hospital electronic data systems, though any portal that is not solely operated by the Hospital, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.

d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE IV. STANDARDS OF PRACTICE

4.1 ADMITTING, ATTENDING AND DISCHARGING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges.

The admitting physician, or designee, is responsible for completion of the history and physical examination and admission orders.

The attending service will be responsible for:

a. the medical care and treatment of each patient in the Hospital;
b. making daily rounds;
c. ordering consultations, if appropriate;
d. the prompt, complete, and accurate preparation of the medical record;
e. necessary special instructions regarding the care of the patient; and
f. completing the discharge summary

The discharging physician, or designee, is responsible for the discharge orders.

4.1.2 Identification of Attending Service

At all times during a patient's hospitalization, the identity of the attending service shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending service are transferred to another Medical Service, a note covering the transfer of responsibility will be entered in the medical record by the attending service.

4.2 COVERAGE AND CALL SCHEDULES

Each practitioner shall provide the Medical Staff Office with a list of designated Medical Staff appointees who have privileges in the same or like specialties, or less ideally by generalists who have expressed a willingness to assume the responsibility for those patients, who shall be responsible for the care of their patients in the Hospital when the practitioner is not available.

4.3 RESPONDING TO CALLS AND PAGES

a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes.

b. Physical Response: Practitioners are expected to respond within one (1) hour, if requested.

4.4 ORDERS

4.4.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal orders are given directly practitioner-to-hospital staff; telephone orders are given practitioner-to hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy.

b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal orders must be signed within seven (7) days by the ordering practitioner or another practitioner involved in the patient's care.

e. Orders for cancer chemotherapy may not be given verbally.

f. Verbal/telephone orders may be given only by practitioners privileged at the hospital or working under training protocols.

4.4.2 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete

c. The identity of the patient is clearly documented with two patient identifiers within the order; and

d. The facsimile contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law.

4.4.3 Cancellation of Orders Following Surgery or Transfer

All previous orders are canceled when the patient:

a. goes to surgery,

b. is transferred to or from a critical care area,

c. is transferred to/from the Psychiatric unit or Rehabilitation unit to an acute care area, or

d. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to “resume previous orders” will not be accepted.

4.4.4 Drugs and Medications

Orders for drugs and medications must follow MacNeal Hospital Medication Ordering and Transcribing Policy.

4.5 CONSULTATION

a. Indications for consultation include, but is not limited to: whenever patients in their care require services that fall outside their scope of delineated clinical privileges, whenever a patient is not a good risk for operation or treatment, when the diagnosis is obscure, when severe psychiatric symptoms are exhibited or when there has been an attempted suicide, or when requested by the patient or family.

b. Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending service will provide written authorization in the EMR requesting the consultation, and permitting the consulting practitioner to attend or examine their patient. This request shall specify:

1. the reason for the consultation, and

2. the urgency of the consultation (urgent or emergent– in a timeframe determined by conversation between the referring physician and the consultant; routine – within 24 hours).

b. All consultations will be for “consultation and treatment” unless otherwise noted as “consultation and recommendation”.

c. Consultants should not order consultations with other specialties without informing the attending physician, unless the need is urgent/emergent.

d. APRNs and physician assistants may perform the consultation, including ordering diagnostics or therapeutics, with the knowledge and collaboration of their collaborating/supervising physician. There should be discussion with the collaborating/supervising physician before any therapeutics or significant diagnostics are ordered.

e. Residents and fellows may perform the consultation, including ordering diagnostics or therapeutics, with the knowledge of their attending physician.

f. The attending physician may utilize consultants of their choice. In general, if a patient has chronic consultative care by a consultant prior to this episode of care, that physician should

be consulted if that medical issue is unstable. If desired, the attending physician may utilize the ED on call list for consultation.

g. If nurses have any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to their manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. When there are concerns regarding the continued stay within a critical care unit, consultation with the medical director of the unit will be obtained.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit is expected to be examined by a physician, or designee, within one (1) hour following admission or transfer unless that transfer is solely for non-critical care reasons such as monitoring of certain IV infusions or for one-on-one observation.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a physician, PA, or APRN within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to the release of dead bodies shall conform to local law.

For inpatients, the attending physician or other privileged physician is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner, in accordance with law.

4.7.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.8 AUTOPSY

It is the responsibility of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest. A Hospital pathologist should perform all autopsies with written consent by the next of kin in accordance with state laws. For all autopsies done in the Hospital, a provisional anatomic diagnosis will be recorded on the medical record within forty-eight (48) hours, and the complete autopsy report will be made part of the medical record within thirty (30) working days unless an explanatory note is written. When autopsies are performed off-site, a provisional diagnosis and the complete autopsy report will be obtained as soon as possible.

4.9 DEATHS REPORTABLE TO THE MEDICAL EXAMINER

Deaths will be reported to the Medical Examiner when required by state law.

4.10 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.10.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership.

4.10.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician(s) is(are) responsible for managing the health care of patients in all settings.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defined by state law.

c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the Advanced Practice Professional.

e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or

other means. A physician must be able to respond telephonically and or physically in a timely manner when needed by the Advanced Practice Professional.

f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician(s).

g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. The physician(s) and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.

i. The supervising/collaborating physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with supervising methods and style of delegating patient care.

j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and any alternate supervising physician(s), as applicable.

4.10.3 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional and the supervising/collaborating physician. The Supervision/Collaboration Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the Advanced Practice Practitioner can provide services to patients at the Hospital.

4.10.4 Supervising/Collaborating Physician

An Advanced Practice Professional may provide services to patients only if the supervising/collaborating physician, or alternate physician, is within normal backup coverage range. A physician may not supervise more APPs than is allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.10.5 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 3.18.

4.10.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Office, or
b. provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

4.11 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties, including hand hygiene.

4.12 EVIDENCE-BASED ORDER SETS

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions.

The Medical Executive Committee may adopt evidenced-based order sets , protocols, and standing orders upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

4.12.1 Order Sets

a. Composition
    i. A menu of listed medications, diagnostic tests or treatment orders designed around an individual physician’s preferences, or a setting for care, or for a specific diagnosis.
    ii. Some of the listed orders may require the privileged practitioner to adapt dosages or to select the treatments for individual patient depicted by check boxes and blank fields for data entry.
a. Ordering
    i. An order from a privileged practitioner must be obtained prior to initiating.
    ii. The order must be authenticated.
b. Development
    i. The order sets should be reviewed and approved by the medical staff.
    ii. When medications are included, pharmacy approval is required.

4.12.2 Protocols

a. Composition
    i. A defined, standardized listing of medications, diagnostic tests or treatments to care for a patient with a specific diagnosis, symptom or diagnostic test.

ii. A protocol differs from a preprinted order set as there are no built-in options to select patient specific orders. Variations in weight-based dosing are included in the protocol.

b. Ordering
   i. Requires an order from a privileged practitioner prior to initiation.
   ii. A copy of the protocol is entered in the medical record when ordered proactively or when implemented in an emergency.

c. Development
   i. The Regional P&T Committee and Regional Order Set Committee is solely responsible for the development of all protocols, which then shall be approved by the Hospital as set forth herein and in accordance with Hospital policy.
   ii. Evidence of a medical staff approval process by the medical staff who will be using them.
   iii. When medications are included, pharmacy approval is required.
   iv. Approval of the CNO is required.

4.12.3 Standing Orders

a. Composition
   i. A defined, standardized listing of medications, diagnostic tests or treatments to care for a patient in emergency situations and other time sensitive situations.
   ii. Requirements include:
      a) Each order must have clear criteria and indications.
      b) Each medication order must be a complete order including clear dosages; medication choices are not acceptable.

b. Ordering
   i. The order is entered into the order section of the record and the Standing Order form entered in record and signed dated and timed by RN when initiated.
   ii. The physician or other practitioner responsible for the care of the patient acknowledges and authenticates the initiation of all standing orders after the fact, with the exception of influenza and pneumococcal vaccines, which do not require such authentication.

c. Development
   i. The Regional P&T Committee and Regional Order Set Committee is solely responsible for the development of all standing orders, which then shall be approved by the Hospital as set forth herein and in accordance with Hospital policy.
   ii. Evidence of a medical staff approval process by the medical staff who will be using them.
   iii. When medications are included, pharmacy approval is required.
   iv. Approval of the CNO is required.

d. Prohibition

   Standing orders may not be used for restraints or seclusion. Standing orders for drugs or medications when a drug or medication is being used as a restraint is prohibited. A drug or medication is deemed to be a restraint only if it is not a standard treatment or dosage for the patient's condition, and the drug or medication is a restriction to manage the patient's behavior or restricts the patient's freedom of movement.

4.13 ROUNDING TIME

Rounds on patient should be conducted optimally between 7am and 7pm. The demands of patient care may require rounding outside of this time frame.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in the MacNeal Hospital Patient Rights, Responsibilities Policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Loyola Medicine Consent Policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital policy delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

Hospital policy delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Loyola Medicine Restraint Use Policy delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Loyola Medicine Policy on Advance Directives and Practitioner Orders for Life-Sustaining Treatment (POLST) delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Institutional Approval of Clinical Research Policy should be followed.

ARTICLE VI. SURGICAL CARE

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

A complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition must be completed for each patient receiving general/regional/MAC anesthesia. Only anesthesiologists, certified registered nurse anesthetists, or physicians privileged to perform deep sedation (which is part of MAC) shall be able to perform these procedures.

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

Moderate and deep sedation is performed under the authority of the Director of Anesthesia Services.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in the MacNeal Hospital Pathology Exclusions policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. The MacNeal Hospital Red Rule Policy shall be followed.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Trinity Health and MacNeal Hospital policies on "Code of Conduct" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff policy on practitioner health and impairment.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include: spouses, domestic partners, parents, parents-in-law, children, stepchildren, siblings, siblings-in-law, grandparents, aunts, uncles, nieces and nephews.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Hospital policy regarding access to medical records of themselves or family members to maintain compliance with HIPAA.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with Employee Health processes on TB testing, influenza vaccination, and any testing/vaccinations.

7.6 COMMUNICATION

All practitioners must maintain one primary current accessible e-mail address on file in the Medical Staff Office.

All practitioners must use the accepted method of communication determined by the MEC.

ARTICLE VIII. ORGANIZATION AND FUNCTIONS OF THE MEDICAL STAFF

8.1 Organization of the Medical Staff

The Medical Staff shall be organized as a departmentalized staff including the following departments:

a. Department of Anesthesiology;

b. Department of Family Medicine;

c. Department of Surgery;

d. Department of Medicine;

e. Department of Obstetrics and Gynecology;

f. Department of Pediatrics;

g. Department of Laboratory Sciences;

h. Department of Psychiatry;

i. Department of Radiology;

j. Department of Dentistry;

k. Department of Emergency Medicine; and

l. Such other Clinical Departments or Sections of Clinical Departments as may be created by resolution of the Medical Staff with the approval of the Board.

A Department Chair shall head each Department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

8.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The Medical Staff officers, Department Chair, hospital and Medical Staff committee chairs, are responsible for working collaboratively to accomplish required Medical Staff functions. This process may include periodic reports as appropriate to the appropriate Department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

8.3 Description of Medical Staff Functions

The Medical Staff, acting as a whole or through committee, participates in or has oversight over the following activities:

8.3.1 Governance, direction, coordination, and action

a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from Departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the Medical Staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned practitioners when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and governing body; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff leaders as well as between Medical Staff leaders and hospital administration and the Board.

8.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the Medical Staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

   i. Medical assessment and treatment of patients

   ii. Use of medications

   iii. Use of blood and blood components

   iv. Operative and other procedures

   v. Education of patients and families

   vi. Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations

   vii. Appropriateness of clinical practice patterns

   viii. Significant departures from established pattern of clinical performance

   ix. Use of developed criteria for autopsies

   x. Sentinel event data

   xi. Patient safety data

   xii. Coordination of care, treatment, and services with other practitioners and

hospital personnel, as relevant to the care, treatment, and services of an individual patient

xiii. Findings of the assessment process relevant to individual performance; and

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to Medical Staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

8.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the Medical Staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

8.3.4 Credentials review (see Part III: Credentials Procedures Manual)

8.3.5 Information Management

a. Review and evaluate medical records to determine that they:

i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance over enforcement of Medical Staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

8.3.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

8.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for

beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

8.3.8 Bylaws review

a. Conduct periodic review of the Medical Staff bylaw, rules, regulations, and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the Medical Staff bylaws, rules, regulations, and policies.

8.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the Medical Staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

8.3.10 Infection Prevention and Control Oversight

a. The Medical Staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:

i. Review of cumulative microbiology recurrence and sensitivity reports;

ii. Review of prevalence and incidence studies, as appropriate; and

iii. Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biennially.

8.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions,

pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by accreditation agencies;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to accreditation standards: to include the review of nutrition policies and practices; including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

   i. Prescribing/ordering of medications;

   ii. Preparing and dispensing of medications;

   iii. Administrating medications; and

   iv. Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and Medical Staff pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

8.3.12 Practitioner Wellbeing

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the impaired practitioner's Department Chair and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Practitioner Wellbeing Committee does not alter the primary responsibility of the Department Chair for clinical performance within that chair's Department;

d. Create opportunities for referral (including self-referral) while maintaining confidentiality to the greatest extent possible; and

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

8.3.13 Utilization Management

a. Study recommendations from Medical Staff members, quality assessment coordinators and others to identify problems in utilization and the review program;

b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate Department or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the Medical Staff Quality Committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, Medical Staff, and administration in matters of privileged communication and legal release of information.

ARTICLE IX. MEDICAL STAFF COMMITTEES

9.1 General Language Governing Committees

The following shall be the standing committees of the Medical Staff: Medical Executive, Credentials, Nominating, Bylaws, Peer Excellence Committee, Utilization Review, and Practitioner Well-Being. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The Chief/President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The Chief/President of the Medical Staff and the CEO and Hospital President, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the Chief/President of the Medical Staff or by action of the MEC for failure to remain a member of the Medical Staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical Staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

9.2 MEC

Description of the MEC is in Part I, Section 6.2 of the Bylaws..

9.3 Credentials Committee

Description of the Credentials Committee is in Part III, Section 1 of the Bylaws.

9.4 Peer Review Committee

9.4.1 **Composition:** The composition of this committee is noted in the committee charter.

9.4.2 **Responsibilities:** The committee shall be responsible for those functions described in section 8.3.2 a-d above.

9.5 Bylaws Committee

9.5.1 **Composition:** The Bylaws Committee shall consist of the Chief Medical Officer (an ex officio member), five (5) members appointed by the President of the Medical Staff who have been members of the Active Medical Staff for at least five (5) years.

9.5.2 **Responsibilities:** The committee shall be responsible for those functions described in section 8.3.8 above.

9.6 Practitioner Wellbeing Committee

9.6.1 **Composition:** The Practitioner Wellbeing Committee shall consist of the at least three (3) Members to serve on this committee.

9.6.2 **Responsibilities:** This committee shall be responsible for those functions described in section 8.3.12 above.

9.7 Nominating Committee (ad hoc)

9.7.1 **Composition:** The Nominating Committee shall consist of at least three (3) Active Members and the CMO/VPMA. The Nominating Committee shall be recommended by the Chief/President of the Medical Staff and appointed by the MEC.

9.7.2 **Responsibilities:** The committee shall provide an annual slate of nominees for the elected Medical Staff positions.

9.8 Utilization Management Committee (hospital committee)

9.8.1 **Composition:** The utilization management committee shall consist of at least two (2) physician members of the Medical Staff. The CMO (local or regional), or CEO and Hospital President if no CMO, shall appoint the hospital representatives to the committee.

9.8.2 **Responsibilities:** This committee shall be responsible for the functions described in section 8.3.13 above.

9.9 Joint Conference Committee (Board committee)

9.9.1 **Composition:** The Joint Conference Committee shall consist of the Officers of the Medical Staff and an equal number of Board members, along with the Hospital President.

9.9.2 **Responsibilities:** This committee serves as a conflict resolution mechanism when issues arise between the Medical Staff and the Board of Directors.

ARTICLE X. CONFIDENTIALITY, IMMUNITY, RELEASES, AND CONFLICT OF INTEREST

10.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or Medical Staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

10.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or Medical Staff. No representative of this healthcare organization acting in good faith and without malice shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

10.3 Covered Activities

10.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;

b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement/peer review activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other hospital, committee, Department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 Releases

When requested by the Chief/President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

10.5 Conflict of Interest

A member of the Medical Staff requested to perform a Board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.