

**SAINT MARY'S HOSPITAL  
MEDICAL STAFF BYLAWS,  
POLICIES AND RULES AND REGULATIONS**

**MEDICAL STAFF ORGANIZATION,  
RULES AND REGULATIONS AND  
FUNCTIONS MANUAL OF  
SAINT MARY'S HOSPITAL**

*Approved by the Medical Executive  
Committee -10/23/07*

*Approved by the Board of Directors-  
12/20/07*

## **ORGANIZATION MANUAL/RULES AND REGULATIONS**

### **AMENDMENTS**

<b>ARTICLE</b>	<b>MEDICAL EXECUTIVE COMMITTEE APPROVAL</b>	<b>BOARD OF DIRECTORS APPROVAL</b>
Article 1.A	06/19/12	06/21/12
Article 2.1	05/07/13	02/20/14
Article 2.L.1 (c)	07/28/09	08/06/09
Article 3.A	05/23/11	06/09/11
Article 3.I.A	06/19/12	06/21/12
Article 3.III.I	06/19/12	06/21/12
Article 3.IV.D,E	09/01/15	10/22/15
Article 3.IV.M	06/01/10	06/10/10
Article III.E	05/07/13	02/20/14

Article IV (B)	07/22/08	08/07/08
Article IV (J)	07/28/09	08/06/09
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## ADDENDA

1. GUIDELINES FOR ADMINISTRATION OF SEDATION AT SAINT MARY'S HOSPITAL
2. POLICY FOR DISCLOSURE OF OUTCOMES OF CARE, INCLUDING UNANTICIPATED OUTCOMES
3. MEDICAL STAFF CODE OF CONDUCT POLICY
4. MEDICAL STAFF POLICY REGARDING LICENSED INDEPENDENT PRACTITIONER HEALTH
5. INSTITUTIONAL PRIVACY AND SECURITY VIOLATIONS BY PRACTITIONER AT SAINT MARY'S HOSPITAL

**ARTICLE 1**  
**DEFINITIONS**

**1.A: DEFINITIONS**

The following definitions shall apply to terms used in this Manual and related bylaws and policies:

- (1) "ALLIED HEALTH PRACTITIONER" means individuals other than members of the Medical Staff who are authorized by law to provide patient care services and whose scope of practice is defined in the Allied Health Practitioners Policy.
- (2) "BOARD" means the Board of Directors of the Hospital which has the overall responsibility for the Hospital.
- (3) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (5) "CREDENTIALING POLICY" means the Hospital's Medical Staff Credentialing Policy.
- (6) "DAYS" means calendar days.
- (7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (8) "HOSPITAL" means St. Mary's Hospital in Waterbury, Connecticut.

- (9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
- (10) "MEDICAL STAFF" means all physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff and granted clinical privileges by the Board to practice at the Hospital.
- (11) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (12) "ORGANIZED MEDICAL STAFF" means a group of licensed independent practitioners responsible for oversight of care, treatment, and services provided by the practitioners with privileges, provides for a uniform quality of patient care, treatment, and services, and for approval and amendment of Medical Staff Bylaws, reports to and is accountable to the governing body.
- (13) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.
- (14) "PODIATRIST" means a doctor of podiatric medicine.

***1.B: TIME LIMITS***

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

***1.C: DELEGATION OF FUNCTIONS***

When a function is to be carried out by a person or a committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

## MEDICAL STAFF COMMITTEES AND FUNCTIONS

### 2.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the committees of the Medical Staff that carry out peer review and other quality/performance improvement functions on behalf of the Board.
- (2) Except as otherwise provided, all standing committee chairpersons and committee members shall be appointed by the Chief of Staff, in consultation with the Medical Executive Committee, and input from the Nominating Committee, subject to review by the Board. Committee chairpersons shall be selected based on the criteria set forth in Section 3.B of the Medical Staff Bylaws.
- (3) Except as otherwise provided, chairpersons and members of standing committees shall be appointed for an initial term of one year, but may be reappointed for additional terms.
- (4) The Chief of Staff, Associate Chief of Staff, and the Chief Executive Officer shall be members, *ex officio*, without vote, on all committees.
- (5) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the Chief Executive Officer. All such representatives shall serve on the committees without vote.
- (6) Certain committees delineated in this Manual, and all committees, task forces and study groups appointed to carry out any peer review duties, functions or responsibilities in this Manual, shall be considered "medical review committees" consistent with state law.



- (7) Peer Review duties, functions, and responsibilities set forth in this Manual or in any related document of the Medical Staff shall be performed by a medical review committee in accordance with Chapter 368a of the Connecticut General Statutes. All reports, recommendations, actions, and minutes made or taken by a medical review committee are confidential and covered by the provisions of applicable state law.

## 2.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet at the discretion of the Chief of Staff and in conjunction with the chairperson and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

## 2.C: ALLIED HEALTH REVIEW COMMITTEE

The composition, duties and meeting requirements of the Allied Health Review Committee are set forth in Section 2.D of the Policy on Allied Health Practitioners.

## 2.D: CANCER COMMITTEE

### 2.D.1. Composition:

The Cancer Committee shall be as defined by the American College of Surgeons Commission on Cancer. Required members include at least one physician representing each of the diagnostic and treatment services as outlined below. Other required members include a representative from each

of the administrative, clinical and supportive services available in the program.

The committee will consist of at least the following:

- (a) one member of the Medical Staff from each of the following specialties: Diagnostic Radiologist, Pathologist, Surgeon (includes general surgeon and/or surgical specialists involved in cancer care), Medical Oncologist; Radiation Oncologist.
- (b) Cancer Liaison Physician.
- (c) Other required members of the committee are: Cancer program administrator, Oncology Nurse, Quality Management representative, Palliative care team member, Clinical research representative, pastoral care and health information representative. Genetics professional/counselor, if these services are provided on site.
- (d) Optional members are Specialty Physicians representing the major cancer experience(s) at the program, American Cancer Society representative, VITAS representative, pharmacist, registered dietitian, behavioral health professional trained in the psychosocial aspects of cancer care.
- (e) Additional cancer committee members are appointed according to the scope of the services offered and the need for additional cancer committee members based on the major cancer sites seen by the program.

#### 2.D.2. Duties:

- (a) The Cancer Committee shall perform the following duties:
  - (1) provide multidisciplinary leadership and coordination in the prevention, detection, treatment and follow-up of cancer care;

- (2) provide consultative services to patients;
  - (3) facilitate the inclusion of major cancer sites into educational programs;
  - (4) evaluate the quality of care provided to patients with cancer;
  - (5) supervise the cancer data system; and
  - (6) appoint members to act as registry physician advisors.
- (b) Details of additional objectives and procedures recommended by the American College of Surgeons are in the Cancer Program Manual.

#### 2.D.3. Meetings, Reports and Recommendations:

The Cancer Committee will meet as often as necessary to fulfill its duties, but at least quarterly. The Cancer Committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee.

#### 2.E: CREDENTIALS COMMITTEE

##### 2.E.1. Composition:

- (a) The Credentials Committee will consist of at least five members of the Medical Staff appointed by the Chief of Staff, with approval of the Medical Executive Committee, for their interest and/or experience in credentialing matters.
- (b) A representative from the Board may serve on the Credentials Committee, *ex officio*, without vote.
- (c) Service on the Credentials Committee shall be considered the primary medical staff obligation of each member, and other medical staff duties, of an administrative nature, shall not interfere.

- (d) Members of the Credentials Committee will agree to serve an initial three-year term subject to annual confirmation. Members may serve an additional three-year term. Thereafter, they must be off the Committee for a period of at least one year before being eligible to serve again.
- (e) All new members of the Credentials Committee, either prior to beginning to serve or while serving on the Committee, are strongly encouraged to obtain specific education and training regarding the credentialing process

2.E.2. Duties:

The Credentials Committee shall, in acting to further the quality of care rendered to patients in the Hospital, perform the following duties:

- (a) review the credentials of all applicants for Medical Staff appointment and clinical privileges, determine the completeness of such applications, and prepare a written report of its findings and recommendations;
- (b) review the credentials of all individuals seeking Medical Staff reappointment and the renewal of clinical privileges, determine the completeness of such applications, and prepare a written report of its findings and recommendations; (Credentialing Policy 3.A.5)
- (c) in conjunction with the Department Chair review and recommend, as questions arise, criteria for new clinical privileges and for privileges that involve different specialties and, upon request from Administration, recommend whether new procedures or services should be offered to patients at the Hospital;

- (d) receive and act on reports from the Allied Health Review Committee regarding allied health practitioners and prepare a written report of its findings and recommendations; and

## 2.F: JOINT CONFERENCE COMMITTEE

### 2.F.1. Composition:

- (a) The Joint Conference Committee shall consist of the following:
  - Three (3) members of the Board and two (2) members of Hospital Administration, designated from time to time by the Chairman of the Board of Directors, and three (3) members of the Medical Staff to be selected as determined by said Staff

### 2.F.2. Duties:

The Joint Conference Committee will perform the following duties:

- (a) This committee shall meet as necessary, and shall consider whatever matters may be of mutual interest to the Corporation and the Medical Staff.
- (b) make recommendations to the Officers, the Executive Committee and the Board of Directors.

## 2.G: MEDICAL EXECUTIVE COMMITTEE

The composition, duties and meeting requirements of the Medical Executive Committee are set forth in Section 5.B of the Medical Staff Bylaws.

## 2.H: NOMINATING COMMITTEE

The composition, duties and meeting requirements of the Nominating Committee are set forth in Section 3.D of the Medical Staff Bylaws

## 2.I: MEDICAL STAFF QUALITY AND SAFETY COMMITTEE:

### 2.I.1. Composition:

The Committee will be chaired by the Medical Director of Clinical Quality. Membership shall include the Chief of Staff, the Chief Medical Officer, and the Chair of the Physician Advisory Committee. Membership shall also include the Chairs of the Departments of Medicine, Surgery, and Obstetrics and Gynecology. Other member may be recommended by the Committee for approval.

### 2.I.2. Purpose:

The Medical Staff Quality and Safety Committee shall assist the organized medical staff in overseeing and ensuring the quality of care delivered by the medical staff at Saint Mary's Hospital. Develop and oversee the implementation of the quality agenda on behalf of the medical staff

### 2.I.3. Responsibilities:

- a) Oversee quality and patient safety delivered to patients by the medical staff.
- b) Serve as a forum for reviewing proposals for the evidence related to introduction of new clinical practice.
- c) Serve as a consultative resource in support of the Credentials Committee regarding proposals for privileges requested outside standard scope of practice for a specialty.
- d) Develop strategies to advance clinical quality and patient safety.
- e) Ensure medical staff departments engage in ongoing and effective peer review.

- f) Make recommendations to the Medical Executive Committee for education for the medical staff regarding quality and patient safety.
- g) Review and approve various clinical performance reports from key medical staff departments by the Department chairs or subsection chiefs.
- h) Make recommendations to the hospital administration regarding clinical quality and patient safety priorities.

2.I.4. Reporting:

The committee is accountable to and will provide regular reports to the Medical Executive Committee. The Committee will also provide regular reports to the Quality and Safety Committee of the Board of Directors.

2.J: ORGANIZATIONAL EXCELLENCE:

2.J.1. Composition:

- (a) The Quality Coordinating Council is a hospital-wide council consisting of the following:
  - (1) members of the Medical Staff appointed by the Chief of Staff;
  - (2) representatives from Administration and patient care services appointed by the Chief Executive Officer; and
  - (3) one or more Board members appointed by the Chairperson of the Board.
- (b) The Chairperson of the Quality Coordinating Council shall be a member of the Medical Staff who may be employed by the Hospital

2.J.2. Duties:

The Quality Coordinating Council will monitor the performance improvement activities carried out in the Hospital.

2.J.3. Reports and Recommendations:

The details of the Quality Coordinating Council's procedures are set forth in the Hospital's Performance Improvement Plan.

2.K: GRADUATE MEDICAL EDUCATION COMMITTEE

2.K.1. Composition:

The Institutional Committee for Graduate Medical Education shall consist of the following:

- (a) the chairpersons of the clinical departments;
- (b) the directors of the residency training programs;
- (c) the Chief of Staff and Immediate Past Chief of Staff
- (d) Residents representing the residency training programs.
- (e) representative of Administration
- (f) hospital librarian
- (g) residency coordinators

2.L: OTHER MEDICAL STAFF FUNCTIONS

- (1) The following functions may or may not require the existence of a separate committee, task force or study group. The Medical Executive Committee is responsible for facilitating and monitoring the performance of the following peer review and performance improvement functions:



- Blood Utilization Review includes:
  - (a) reviewing procedures for distribution, handling, use, and administration of whole blood and blood components;
  - (b) reviewing the adequacy of transfusion services for patient needs;
  - (c) reviewing actual or suspected transfusion reactions; and
  - (d) evaluating blood usage, including a review of the amount of blood requested, the amount of blood used, and the amount of blood wasted.
- Continuing and Post-Graduate Medical Education includes:
  - (a) organizing and supervising locally presented continuing medical education opportunities; and
  - (b) supervising the professional library.
  - (c) keeping activities relevant to services performed in the health system and/or community
  - (d) using QCC data from MEC to help prioritize activities.
- Infection Control Review includes:
  - (a) adopting a working definition of Hospital-associated infections;
  - (b) developing standards for surveillance of incidence of nosocomial infection and conditions predisposing to infections;
  - (c) developing a mechanism for monitoring and reporting infections in patients and environmental conditions with infection potential;

- (d) developing a mechanism for evaluation of infection and environmental infection potential, including identification, where possible, of Hospital-associated infections, and periodic review of the clinical use of antibiotics in patient care; and
  - (e) developing control measures, including isolation policy, aseptic techniques, and a personnel health program.
- Medical Records Review includes:
    - (a) reviewing and determining that each medical record, or a representative sample of records, is complete and consistent and reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge;
    - (b) conducting periodic reviews of summary information regarding the timely completion of all medical records;
    - (c) reviewing Medical Staff policies and/or rules pertaining to medical records, including medical record completion, filing, indexing, storage, destruction and availability, and recommending changes as appropriate and/or necessary;
    - (d) reviewing at least biannually the policies and procedures of the medical records department pertaining to medical record completion, filing, indexing, storage, destruction and availability, and

making recommendations as appropriate and/or necessary; and

- (e) recommending a medical record abbreviation list and a list of abbreviations that should not be used.
- Pharmacy and Therapeutics Review includes:
  - (a) reviewing the appropriateness of the prophylactic, empiric and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;
  - (b) maintaining and periodically reviewing the hospital formulary or drug list and considering requests to add to or delete from the formulary;
  - (c) recommending drugs to be stocked on the nursing unit floors and by other services;
  - (d) recommending policies concerning the safe use of drugs in the Hospital, including new drugs, drug preparations requested for use in the Hospital, hazardous drugs and investigational drugs; and
  - (e) monitoring guidelines for automatic stop orders for drugs as specified in the Rules and Regulations or other hospital policy.
- Practitioner Health Review includes:
  - (a) reviewing and facilitating further evaluation and treatment and making recommendations regarding any practitioner impairment concerns raised in accordance with the Hospital's policy on practitioner health issues;

- (b) recommending educational materials that address practitioner health and emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional illness; and
- (c) handling impairment matters in a confidential fashion and keeping the Chief of Staff and the Chief Executive Officer apprised of the matters under review.
- Surgical and Tissue Review includes:
  - (a) conducting a comprehensive review to examine justification of surgery performed, whether tissue was removed or not;
  - (b) evaluating the acceptability and the quality of the procedure chosen, including, but not limited to, the administration of anesthesia;
  - (c) evaluating complications; and
  - (d) evaluating the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses and making a written report reflecting the results of all evaluations performed and the actions recommended.
- Utilization Review includes:
  - (a) monitoring utilization to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services; and

- (b) evaluating the medical necessity of continued hospital services for particular patients, and making recommendations on the same to the attending physician, the Medical Executive Committee and the Chief Executive Officer.
- (2) Information from the above reviews will be made available to the department chairperson on an ongoing basis for the purpose of encouraging performance improvement. This information will also be included as part of each member's performance profile to be considered at reappointment and at other relevant times.

## ARTICLE 3

### RULES AND REGULATIONS

The policies, rules and regulations are required to ensure quality of care and comply with Joint Commission, CMS, and State of Connecticut regulations.

#### MEDICAL STAFF RULES AND PROCEDURES

##### **I. ADMISSION AND DISCHARGE OF PATIENTS**

- A. A patient may be admitted only by a practitioner with admitting privileges. A patient's general medical condition is managed and coordinated by an attending physician. Admitting orders may be written by a resident physician under the direction of, and by discussion with, the attending physician. All other resident orders may be written independently as long as they are in alignment with the attending physician directed plan of care.
- B. A provisional diagnosis is provided by the attending physician prior to the patient's admission, except in cases of emergency, in which case the diagnosis is given as soon as possible after admission. Any non-surgical practitioner booking an elective admission with a known surgical diagnosis must name the surgical consultant at the time of admission.
- C. Admissions to and discharges from intensive care units, and other special care areas, shall be in conformity with the specific policies developed for such units.
- D. The attending physician's responsibility includes:
  - 1. Care, treatment and coordination of the care of the patient among the practitioners involved in the patient's care.
  - 2. Prompt completeness and accuracy of the patient's medical record.

3. Instructions to Hospital personnel regarding the patient's care.
  4. Providing reports of the condition of the patient for the patient's relatives and (if applicable) the referring practitioner.
- E. The admitting practitioner is responsible for providing information necessary to ensure the protection of other patients and the hospital staff, e.g. communicable diseases, and to provide such information as may be necessary to assure the protection of the patient from self harm.
- F. The physician who arranges for the admission of a patient to the hospital shall be designated as the Physician of Record and shall be responsible for the care of that patient unless transfer to another physician is made in writing. This physician then becomes the Physician of Record. In the event of a surgical procedure performed in the Operating Room, the patient will be transferred automatically to the Surgeon of Record unless the Operating Surgeon indicates in writing on the order sheet that the patient is to be retained by the original Physician of Record. At the time of discharge, the current Physician of Record shall document the final diagnosis, sign and date the record.
- G. Each staff member provides the name(s) of the practitioner(s) who is to be called in the physician's absence. Covering practitioners are required to hold appropriate clinical privileges for the purpose of proper coverage, and are required to be physically present in the Hospital on a timely basis. Departmental Rules and Procedures may specify appropriate requirements for covering practitioners.

If the staff member does not reside in the hospital defined local community, he provides the name of a covering practitioner who is resident in the area.

If no alternate practitioner is available in an emergency, the chairman of the relevant clinical department or his designee provides for the patient's care.

- H. Attending practitioners cooperate with the utilization review, quality and safety functions by being sure that the patient record includes at least:
1. Reason for admission (What is to be done for the patient as an inpatient that cannot be done as an outpatient?)
  2. Estimated time the patient will need to be in the hospital.

3. Plans for post-hospital care, including early referral to discharge

## **II. INFORMED CONSENT**

Except in emergency situations, the responsible physician or dentist shall obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate, including transfusion and the use of blood products, and provide evidence of consent either by a form signed by the patient (or the patient's authorized representative), or by a written statement signed by the doctor in the patient's hospital record. The extent of information to be supplied by the doctor to the patient shall include the specific procedure or treatment, or both, the reasonably foreseeable risks, and reasonable alternatives of care or treatment.

In all surgical procedures the doctor in whose name the permission for operation is obtained shall participate in person as a member of the operating team and shall be present during the critical portion of the procedure. Such participation shall not be delegated within the informed consent of the patient or the patient's authorized representative.

In the case of an emergency, if time permits the doctor shall confer with another doctor, document the need for the surgery or special procedure, and notify the Administration.

Attached see sample Informed Consent.

If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to at the same time and reflected on a single form.

## **III. ORDERS AND PRESCRIPTIONS**

- A. Drugs and medications to be administered to patients shall be those listed in the hospital formulary.
- B. "Stop Orders:"
  1. Narcotics and sedatives ordered without time limit or a specified number of doses are automatically discontinued after seventy-two hours.
  2. Antibiotics ordered without time limit or specific number of doses are automatically discontinued after fourteen (14) days..



3. Automatic stop orders for other drugs may be established from time to time by joint agreement of the Medical Executive, the Nursing Department, and the Pharmacy.
- C. There are no “standing orders” or requirements for any admission laboratory procedures.
  - D. When a patient goes to surgery, previous orders are canceled and new orders must be written immediately postoperatively.
  - E. All orders for treatment (including orders transmitted by telefacsimile) must be in writing or preprinted, signed, dated, and timed. Verbal orders are discouraged. Telephone orders are acceptable under limited circumstances, i.e. only when it is highly impractical for orders to be written (or written & transmitted by telefacsimile) to address urgent patient needs during off hours. Telephone orders that meet this criteria must be dictated to a duly authorized person functioning within his/her sphere of competency, and must be “read back” to the medical staff member.

The following orders shall be signed within forty-eight hours:

1. Orders for controlled substances.
2. Orders dictated to a Dietitian/Nutritionist
3. Orders dictated to a Pharmacist.

It is expected verbal orders will be signed by the responsible practitioner in a timely fashion during the hospital stay, but it is the responsibility of the attending of record that such orders be signed.

Orders which are illegible or improperly written will not be carried out by the nursing staff until rewritten or explained. The nursing staff shall contact the attending physician immediately for a clear order.

- F. If a nurse cannot follow an order for any reason the following lines of communication should be used:
  1. The staff nurse should report her concern immediately to the Lead RN, Charge Nurse, or the shift supervisor. The Lead RN or Charge Nurse will discuss the problem with the physician who wrote the order.

2. The Lead RN, Charge Nurse, or shift supervisor will promptly discuss this with the Attending Physician of Record.
  3. If the problem is not resolved at this level, the Director of Nursing will consult with the Vice President of Patient Care Services.
  4. If the problem is of such magnitude that the Vice President of Patient Care Services requires consultation, the Vice President of Patient Care Services will seek the advice of the Chief of Staff.
  5. If the problem is not resolved at this level, the Vice President on Patient Care Services and Chief of Staff will seek consultation with the President/CEO.
- G. Continuous narcotic infusion shall be administered in accordance with Department of Nursing procedure.
- H. Use of restraints shall be in accordance with Department of Nursing Policy.
- I. Requirement for ordering Hospital Outpatient Services:
- a. Non-invasive testing (e.g. lab tests, non-contrast imaging, respiratory therapy, rehabilitation services, sleep studies, etc) –the practitioner must be licensed in the state in which they practice, be responsible for care of the patient, and be acting within their scope of practice.
  - b. Invasive testing (e.g. blood transfusions, chemotherapy, IV antibiotics, Interventional Radiology procedures, etc) –the practitioner must meet the above criteria and be a member of the medical staff.
  - c. Individual departments servicing the outpatient community are responsible for the verification of the practitioner’s license and/or active medical staff privileges, along with confirming that the referring practitioner is responsible for the care of the patient.

#### **IV. THE PATIENT’S MEDICAL RECORD**

- A. The patient’s medical record, like the patient, is the responsibility of the attending practitioner. The record’s contents must include at least:
1. Identification data
  2. Complaint or condition

3. History—personal, family and present illness
  4. Results of physical examination
  5. Provisional diagnosis
  6. Planned medical and/or surgical treatment
  7. Daily progress notes.
  8. Reports, such as laboratory and radiology services, consultations, therapists notes, etc. The reports of ancillary services shall be on the patient's chart within twenty-four hours unless there are extenuating circumstances.
  9. (If applicable) Operative report
  10. (If applicable) Pathological findings
  11. Discharge summary.
  12. Informed Consent form
  13. Final diagnosis
  14. Condition on discharge.
- B. A complete history and physical examination shall in all cases be written and/or dictated within twenty-four hours after the admission of the patient. (History and Physical Requirements attached to Medical Staff Bylaws)

Operative notes shall be completed immediately after surgery. Telephone orders shall be authenticated as stated in Article III, Item E of these rules and procedures. Failure to comply with this rule may result in suspension of admitting and operating room booking privileges after due notification.

A full (comprehensive) operative or high risk procedure (i.e. invasive) note must be dictated or written immediately (upon completion of the operative or procedure, before the patient is transferred to the next level of care) and will include the name of the licensed independent practitioner and assistants, procedure(s) performed and description of the procedure, findings, estimated blood loss (EBL), and specimen removed and postoperative diagnosis. All full reports must be dictated within 24 hours after the procedure. Failure to do so may result in suspension of operating room and procedure privileges.

If the full operative or high risk procedure report cannot be entered into the record immediately after the operation or procedure, an operative or high risk procedure Progress Note is entered immediately after the procedure to provide pertinent information for anyone required to attend the patient.

This Progress Note shall contain the following elements:

- Name of primary surgeon and assistants
- Findings
- Procedure performed
- Estimated blood loss
- Specimens removed
- Postoperative diagnosis

- C. Scheduled operations or potentially hazardous diagnostic procedures are canceled if the patient's record does not include a history and physical examination.
- D. Progress notes are written daily. The content of the note shall be sufficient information to permit continuity of care.
- E. Procedure reports include a detailed account of the findings of the procedure as well as the details of procedural technique.
- F. Procedure notes are written (or dictated) immediately following the procedure. Noncompliance will result in a delinquent record and the practitioner shall be subject to remedial action in accordance with Medical Staff policy.
- G. Symbols and abbreviations may be used in the patient's record only when they have been approved by the medical staff. (An official record of approved abbreviations should be kept on file in the Medical Records Department.
- H.. Consultant's notes must show the consultant's pertinent findings, opinions, and recommendations. (A limited statement such as "I concur" does not constitute an acceptable report of a consultation.)
- I. A discharge note or summary is written or dictated on all medical records of patients who have been admitted, who have had a length of stay of 23 hours, or if required by current Hospital and Medical Staff policy. Discharge summaries should not be dictated or written more than twenty-four (24) hours prior to discharge. All summaries dictated or written more than twenty-four (24) hours prior to discharge must be updated at time of discharge.

- J. All patient medical record entries must be legible, complete, dated, timed, and authenticated in writing or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
- K. Written authorization of the patient (or the patient's authorized representative) is required for release of medical information to persons not otherwise entitled to receive this information.
- L. Original records may be removed from the hospital only in accordance with legal process (e.g. a court order, subpoena, or search warrant). Unauthorized removal of patient records from the hospital by a practitioner is grounds for disciplinary action under the Bylaws.
- M. The Medical Executive Committee will establish a method to address medical record completion. Medical records not completed within seven (7) days following assignment to the responsible physician shall be reported to the appropriate Chief of the Department. The Chairperson of the Medical Records Committee will notify in writing the practitioner of his/her responsibility to complete that record within the next fourteen (14) days. After fourteen (14) days, a letter will be forwarded to the Medical Records Committee Chair notifying the responsible practitioner that the chart remains incomplete. After twenty-one (21) days, the Chief of Staff will forward a letter indicating temporary suspension will become effective if records are not completed within fourteen (14) days of receipt.

Further failure to complete the medical records in another sixty (60) days will result in the loss of Medical Staff Appointment. Loss of staff appointment may also result from three temporary suspensions within any twelve (12) month period. The conduct just described shall constitute a voluntary relinquishment of all clinical privileges and resignation from the medical staff. Upon completion of all delinquent medical records, such physician may then reapply for appointment to the medical staff through the usual appointment process which will also entail an application fee of five hundred dollars (\$500) payable to the Medical Staff Dues Account. During such application process, the practitioner will not be granted temporary privileges, reinstatement will only be granted upon approval of the Board of Directors.

- N. Medical records forms may be modified or substituted for only with the approval of the Medical Executive Committee, except those forms developed in the clinical pathway process with input from representatives of Medical Records, Quality Management, and the Chairman of the Department involved.

- O. Concurrent review of inpatient histories and physical examinations is the responsibility of the Department Chair. A daily list of H&Ps is sent to the Medical Records Department in the A.M. A corrected list then is forwarded to the Chair of the Department.

## V. CONSULTATIONS

Except in emergency, consultation is required in the following situations:

- A. In instances in which the patient exhibits severe psychiatric symptoms or suicidal tendencies and the patient is not under a psychiatrist's care.
- B. When the patient or his family requests a consultation.
- C. An obstetrical consultation is mandatory on any pregnant patient admitted to the hospital with other than an obstetrical diagnosis. Should the patient's obstetrician not be available, or should he/she fail to respond, it will be the responsibility of the primary physician to seek a formal consultation from a staff obstetrician after discussion with the patient.
- D. The consultant shall make and sign a record of his/her findings which must be written or dictated and dated within twenty-four (24) hours of rendering consult. An interim consultation progress note should be written immediately if the consult is dictated. If the initial consultation is performed by an Advanced Practice Provider, the supervising consulted physician must review, modify and sign the consultation within 24 hours of the requested consult.
- E. If a consultation is required by an attending physician, then the attending physician and consulting physician together shall determine the timeliness of the consultation. If there is no agreement between them, then the opinion of the attending physician shall prevail. If the attending physician of record who is requesting the consultation feels the patient should be seen in person by the consulting attending physician and not a midlevel provider and makes the request directly to the consulting physician, the consulting physician must see the patient in person. In the event there are any complaints concerning the timeliness of the consultation from health professionals or other interested parties, these letters will be directed to the Department Chair who will be required to send a copy to the Chief of Staff. If a problem cannot be resolved within the department, it will be referred to the Chief of Staff and the Medical Executive Committee. If this is not brought to satisfactory conclusion, the Board of Directors will be asked to intercede.

If a nurse has a legitimate reason to question the medical regimen of care given to a patient or lack thereof, the protocol in Article III, Item F, 1 - 6 of these rules and procedures shall be followed.

## VI. GENERAL RULES REGARDING SURGICAL CARE

### A. Scheduling of Operations

1. The scheduling of operations shall be as outlined in the Operating Room Policies.
2. Priority. Elective surgery shall be scheduled on a first come, first served basis.

Emergency procedures shall be given priority of scheduling during the regular work day and shall be arranged with the operating room supervisor, who shall give preferential assignment depending on the nature of the emergency. The supervisor has the prerogative of reassigning elective cases to a later time on the schedule to accommodate an emergency procedure.

3. Loss of Priority. The operating schedule begins at 7:45 A.M. at which time the surgeon must be in the operating room. In no cases will the operating room be held longer than fifteen (15) minutes after the scheduled time. Concern for the well being of the patient demands that scheduled times be firmly adhered to.
4. Scheduling Period. The usual schedule of operations begins at 7:45 A.M. A surgeon may request an earlier beginning time by special arrangement with the operating room supervisor.

### B. Information required to schedule an operation

At the time of scheduling an operation, the following information must be given:

1. Name of patient
2. Type of procedure
3. Type of anesthesia (Local or general should be specified.)
4. Name of operating surgeon
5. Age of patient.

### C. Change of Schedule



A change in the schedule may be made only on consultation with the operating room supervisor or the person acting for her in her absence.

D. Emergency Operations

1. Emergency procedures during the regular operating schedule shall be arranged by the operating room supervisor.
2. Emergency procedures outside of the regular operating schedule shall be covered by on-call operating room personnel and may be carried out as soon as the patient is properly prepared.

E. Informed Consent

Please refer to Rule II above.

F. Requirements Prior to Induction of Anesthesia

Proper identification of the patient shall be made prior to induction of anesthesia.

Except in emergencies, the preoperative diagnosis, the history and physical examination (at least in dictated form), and the required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. Laboratory work-ups must have been performed within a reasonable amount of time prior to surgery based on the opinion of the attending physician. In an emergency, the practitioner shall make at least a note including a tentative diagnosis and pertinent findings on the progress sheet prior to induction of anesthesia and start of surgery.

G. Surgical Pathology Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operating room or suite at the time of removal. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. Receipt by the laboratory of surgically removed specimens for examination shall be documented, and the identity of the specimens/patients shall be assured throughout the processing and storage.

Every gross specimen sent to the laboratory shall be examined by a pathologist. The determination of which categories of specimens require only a gross description and diagnosis shall be made conjointly by the

pathologist and the medical staff, and documented in writing. Any decision to rely only on gross diagnosis requires considerable judgment and should be made sparingly.

Exceptions to sending specimens removed during the surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exception, and when another suitable means of verification of the removal has been routinely employed, and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens which may be exempted from the requirement to be examined by a pathologist include, but are not necessarily limited to, the following:

Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

Therapeutic radioactive sources, the removal of which should be guided by radiation safety monitoring requirements;

Traumatically injured members that have been amputated and for which examination for either medical or legal reason is not deemed necessary;

Foreign bodies (e.g. bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

Specimens known to rarely, if ever, show pathological change and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant.

Placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics; and

Teeth, provided the number, including fragments, is recorded in the medical record.

- H. The anesthetist or anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, choice of anesthesia (general, regional, spinal, or local monitored anesthesia care), informed consent, and post-anesthetic follow-up of the patient's condition.
- I. If conditions permit, contamination cases will be scheduled at the end of day's schedule. If this is not possible, the operating room utilized for

contaminated cases must be terminally cleaned, and time allowed for this.

## J. Dental Surgery

A patient admitted for dental treatment is a dual responsibility involving the dentist and the physician member of the medical staff.

### 1. Dentist's Responsibility

- a. A detailed dental history justifying hospital admission.
- b. A detailed description of the examination of the oral cavity and preoperative diagnosis.
- c. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth removed. Refer to paragraph I above regarding tissue and fragments being sent to the hospital pathologist.
- d. Progress notes as are pertinent to oral condition.
- e. Clinical resume (or summary statement).

2. Oral and maxillofacial surgeons may be granted privileges to admit patients to inpatient services for oral and maxillofacial surgery; to perform and record the history and physical examination; and to assess the medical, surgical, and anesthetic risk of operative or other procedures. Such privileges would have to be requested and obtained through the usual credentialing procedures as set forth in the bylaws.

### 3. Physician's Responsibility

- a. Medical history pertinent to the patient's general health.
- b. A physical examination to determine the patient's condition prior to anesthesia and surgery.
- c. Supervision of the patient's general health status while hospitalized.

4. The discharge of the patient shall be on written order of the dentist member of the medical staff. If the patient has a medical problem,

the dentist should discharge the patient to the care of the attending physician

K. Podiatric Surgery

A patient admitted for podiatric surgery is a dual responsibility involving the podiatrist and physician member of the medical staff.

1. Podiatrist's Responsibility

- a. A detailed podiatric history justifying hospital admission.
- b. A detailed description of the examination of the foot and preoperative diagnosis.
- c. A complete operative report describing the findings and technique. Refer to paragraph I above regarding tissue and fragments being sent to the Hospital pathologist.
- d. Progress notes as are pertinent to the postoperative condition.
- e. Clinical resume (or summary statement).

2. Physician's Responsibility

- a. Medical history pertinent to the patient's general health.
- b. A physical examination to determine the patient's condition prior to anesthesia and surgery.
- c. Supervision of the patient's general health status while hospitalized.

3. The discharge of the patient shall be on written order of the podiatrist member of the medical staff. If the patient has a medical problem, the podiatrist should discharge the patient to the attending physician.

4. Postoperative orders are the joint responsibility of the attending physician and the podiatrist.

### 3.A: METHOD OF ADOPTION AND AMENDMENT

- (1) This Manual may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.
- (2) At least 14 days prior to the Medical Executive Committee meeting, members of the Medical Staff shall be notified that copies of all proposed amendments are available in the Medical Staff Office. Any member of the Medical Staff may submit written comments to the Medical Executive Committee.
- (3) In case of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the Board of Directors may provisional approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary a revised amendment is then submitted to the Board of Directors for action.

No amendment shall be effective unless and until it has been approved by the Board.



ADOPTION

This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or hospital policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or Medical Staff committee shall be undertaken pursuant to the requirements of the bylaws or this Manual.

Adopted by the Medical Staff on:

Date: November 1, 2005

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Chief of Staff

Approved by the Board of Directors:

Date: December 8, 2005

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Secretary, Board of Directors

## **Institutional Privacy and Security Violations by Practitioners at Saint Mary's Health System**

All members of the medical staff at Saint Mary's Hospital are given access to the hospital's information systems which contain protected health information. As a prerequisite to this access, practitioners agree to access only that information which is pertinent to care of their patients. Any practitioner who breaches confidentiality is subject to disciplinary action. Violations of protected health information – which then defines the extent of the potential disciplinary action – are categorized as to the level of severity.

- Level I Violation – This represents a minor violation that is considered to be accidental, non-malicious in nature, and/or due to lack of proper training. This may include, but is not limited to:
  - a) Password sharing
  - b) Failing to sign off a given computer terminal
  
- Level II Violation – this is a moderate violation in which the intent of the violation is unclear and evidence cannot be substantiated as to possible malicious intent. Multiple Level I violations may move to this category. This may include, but is not limited to:
  - a) Accessing a patient record without a legitimate reason, including the medical record of a spouse, friend, co-worker, child of legal age, etc.
  - b) Releasing patient data inappropriately, such as to non-authorized individuals
  - c) Using another co-worker's access code without the co-worker's authorization.
  
- Level III Violation – This represents a severe violation in which the physician purposefully breaks the terms of the Medical/Dental Staff Confidentiality. Here, evidence suggests malicious intent and/or there have been multiple violations. The level III violation may include, but is not limited to:
  - a) Releasing data for personal gain
  - b) Destroying or falsely altering data intentionally
  - c) Releasing data with the intent to harm an individual or the hospital.

Corrective Action – Any practitioner found by Saint Mary's Hospital to have violated the policy will be subject to appropriate disciplinary action up to and including termination of hospital privileges. It is the responsibility of the Medical Executive Committee to determine the appropriate disciplinary action. Possibilities for corrective actions might include the following:

- 1) Warning letter describing the incident and how it violated our policy.
- 2) Warning letter along with a 6 month probationary status.
- 3) A meeting with the Chief of Staff and Risk Manager to discuss the violation.
- 4) Fine (Minimum \$200 to Maximum \$1000).
- 5) Suspension of Privileges (3 days to 1 month).
- 6) Removal from the medical staff.

Approved by the Medical Executive Committee 02/26/08

Approved by the Board of Directors 03/13/08



