MEDICAL STAFF RULES AND REGULATIONS

SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS

1.1 General Admitting Policy

The hospital shall admit patients with all types of diseases, providing facilities are available for care of the patient and protection of the hospital personnel and visitors.

1.2 Admitting Privilege

Inpatients may be admitted to the hospital by members of the Active Medical Staff or approved allied health professional. Consulting Medical Staff members may admit inpatients for up to 24 hours provided the consulting physician is locally available for patient management through discharge. Stays longer than 24 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility. All practitioners shall be governed by the official admitting policy of the hospital.

Consulting Medical Staff members who are employed by federally or state-operated health care institutions located within seventy-five (75) miles of the Medical Center, with the approval of the Medical Executive Committee and the Governing Board, may receive extended clinical privileges to provide clinical or surgical care at the Medical Center which is not available at such federally or state-operated health care institutions, but which can be provided at the Medical Center. Patients of these Consulting Medical Staff members may admit patients for these clinical or surgical procedures for periods of up to 96 hours provided the consulting physician is locally available for patient management through discharge. Patient stays longer than 96 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility if necessary.

1.3 Dentist/Podiatrist Admissions

A dentist or podiatrist with clinical privileges may, with the concurrence of a member of the active medical staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for dental or podiatric care must be given the same basic medical appraisal as patients admitted for other services.

1.4 General Responsibilities of Admitting Practitioner.

A member of the medical staff or allied health professional staff shall be responsible for the medical care and treatment of each patient in the hospital, for providing a clear and accurate system for identifying and determining the attending, treating, or on-call physician for his/her patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient.

The following list will apply to every admitting practitioner:

1. Active medical staff or allied health providers with admitting privileges will be provided a document via certified mail with return receipt quarterly reflecting the respective physician or provider's preference of phone numbers they wish to be contacted at and the order in which they are to be used.

2. Each physician or allied health provider will be required to provide at a minimum a primary and backup phone or paging number.

3. Each physician or allied health provider will be required to review, update if necessary, sign and date, and return via FAX to Summit Healthcare's Medical Staff Services Department (928) 537-8839.

4. The Physician Contact Preference List will be updated and placed on the hospital intranet.

5. Each respective department manager or designee will be responsible for ensuring that a new list is printed regularly and made available for staff in their respective departments. The outdated list will be destroyed in a non-retrievable manner.

6. The attending or treating physician or provider will be required to respond to calls or pages with in thirty (30) minutes.

7. The attending or treating physician or provider will be responsible for informing their respective office staff, answering or paging service if or when care or call responsibility has been transferred to another treating physician or provider.

8. A central log will be established in applicable hospital departments that documents time of call, number called, and time of response or no response.

9. If a clinical situation necessitates immediate intervention prior to the response to a call or page or the thirty (30) minute time standard, either the Rapid Response Team or Emergency Physician will be requested to assess and manage the patient.

10. Failure of the attending or treating physician or provider to respond to a call or page within thirty (30) minutes will result in the completion of an occurrence / incident report.

11. The manager or designee for the department in which the occurrence / incident report was initiated will review the call log and verify the Physician Contact Preference List was applied correctly.

12. If it is determined that hospital staff applied the Physician Contact Preference List incorrectly, the hospital's corrective action process will be initiated and an occurrence / incident report will be completed.

13. All occurrence / incident reports involving staff physicians or allied health providers with admitting privileges, active or consulting, will be reviewed by the Department Medical Director for appropriateness.

14. Occurrence / Incident reports deemed appropriate will be forwarded to the attention of both the Medical Staff Services and Performance Improvement Department(s) for trending purposes.

15. Policy non-compliance will be defined as six (6) or greater occurrences with in the two (2) year reappointment cycle.

16. Policy non-compliance will result in a Notice of Non-Compliance being forwarded to the attention of the respective physician and activation of the "Disruptive Physician" rule and regulation: Summit Healthcare Medical Staff Rule and Regulation, Section 10, Disruptive Physician.

17. Prior to any notice of non-compliance being forwarded to the attention of the respective physician, or activation of Medical Staff Rule and Regulation Section 10, hospital administration will confer with the Chief of Staff.

1.5 Patient Admissions and Observation Services

Active medical staff physicians or approved allied health professional shall admit/observe patients as follows:

a) Notice of Admission:
Except in emergency circumstances, the admitting practitioner shall first contact the receiving unit Administrative Shift Coordinator or designee of the intended admission/observation to ascertain the availability of a bed and assure appropriateness of the admission/observation.

b) Justification for Admission and Diagnosis:
Except in emergency circumstances, patients shall not be admitted to the hospital until a valid reason (criteria) for admission has been stated. In the case of an emergency, such statement is recorded as soon as possible.

All patient admissions must meet acute care or observation criteria at the time of the admission. The admitting practitioner shall provide appropriate documentation in the medical record to justify the patient's acute status.

c) Determination of Hospital Disposition Status:
Except in emergency circumstances, the admitting practitioner shall state/document the patient's admission status in the medical record with one of the following:

Admit to Inpatient' - For patients meeting inpatient admission criteria.
Place in Observation Services- For patients meeting outpatient observation criteria.
Disposition per Protocol – Delegates documentation to authorized hospital Staff

(Rev 11/09)

d) Practitioners shall hospitalize patients according to criteria set forth by CMS /Medicare or other approved criteria (inpatient vs. observation) and the Medical

Executive Committee (ICU vs. Med/Surg vs. OB.) (Rev 04/10)

e) Disposition status is to be authenticated within 24 hours. (Rev 07/11)

1.6 Continued Stay

Patients who require continued stay must meet acute care criteria daily. The practitioner shall provide appropriate documentation in the chart to justify the patient's continued acute status.

1.7 Emergency Admission Without PCP

A patient to be admitted on an emergency basis that does not have or is unable to designate a private practitioner will be assigned to an Active Medical Staff member with admitting privileges in the appropriate service to attend him.
(Rev. 11/09)

1.8 Practitioner Responsibility for Staff/Patient Safety

The admitting practitioner shall be held responsible for giving such information as he possesses which may be necessary to assure the protection of others whenever his patients might be a source of danger from any cause whatever and to assure protection of the patient from self harm.

1.9 Precautions in the Suicidal Patient

For the protection of patients, the medical and nursing staff and the hospital, precautions to be taken in the care of the potentially suicidal patient include:

A. Any patient known or suspected to be suicidal in intent shall be admitted to the unit appropriate to the medical condition and suicide precautions followed.

B. Any patient known or suspected to be suicidal must have a consultation by a mental health professional within 24 hours of admission and the consultation documented.

1.10 Triage

Triage situations, in any department of the hospital, require practitioners to actively collaborate with hospital personnel. During triage circumstances, the following applies:

a) The practitioner shall contact the receiving unit Charge Nurse or designee for admission requests to determine bed availability.
b) The practitioner shall assist in facilitating timely discharges and transfers as appropriate.
c) The Triage Officer (first call physician for the emergency department) shall assist as needed/requested.
d) Patients are admitted according to severity of illness. Emergency admissions receive priority followed by urgent admissions. Elective admissions (such as surgeries) may be rescheduled as deemed necessary. Circumstances may require patients to be

transferred to another acute care facility if beds are not available.

1.11 Transfers

a) When patients are discharged and sent to another licensed healthcare institution as an inpatient or resident without the intent of returning to the sending hospital, practitioners shall follow federal/state standards. The attending practitioner is responsible for:

i. ordering the patient transfer
ii. determining the patient's condition for transfer – stable versus unstable
iii. discussing the risks/benefits/ reasons of the transfer based upon the patient's medical condition and mode of transfer with the patient or patient's representative
iv. discussing the type of facility where the patient's continuing care needs will be best met
v. providing the receiving physician with report on the patient's condition (acute care transfers only)
vi. determining the level of care and mode the patient requires during transfer
vii. signing or countersigning the certification/consent
viii. documenting thoroughly

b) Transfer/Discharge Summary must be dictated and marked as STAT prior to the transfer of the patient.

c) When patients are transferred from one level of care to another within the hospital all previous physicians' orders are cancelled. (Rev 07/11; 11/09)

1.12 Transports – Sending and Receiving

When patients are sent to another health care institution for outpatient medical services with the intent of returning to the sending hospital, practitioners shall follow federal/state standards. The attending practitioner is responsible for:

a) SENDING: When patients are sent to other facilities for outpatient medical services not available at Summit Healthcare, practitioners shall follow federal/state standards. The attending practitioner is responsible for:
- ordering the patient transport
- discussing the risks/benefits/reasons of the transport based upon the patient's medical condition and mode of transfer with the patient or patient's representative
- determining the level of care the patient requires during transport
- signing or countersigning the certification/consent for transport
- documenting thoroughly

b) RECEIVING: When patients are received from another hospital for Summit Healthcare outpatient medical services practitioners shall follow federal/state standards. The attending practitioner is responsible for:
- ordering the patient transport
- determining the level of care and mode the patient requires during transport
- documenting thoroughly

1.13 Discharges

a) Discharge planning is initiated in a timely manner. Alternative levels of care and post-hospitalization needs are considered and discussed with the patient/family and discharge planning staff.

b) Patients shall be discharged only by order of the attending practitioner or designee and with patient instructions regarding diet, medication, activity, bathing, follow up and other special instructions as pertinent to the patient's status.

1.14 Death

In the event of a `hospital death, the deceased shall be pronounced dead by the attending practitioner, another practitioner on staff or two licensed registered nurses within a reasonable time. Policies with respect to release of dead bodies shall conform to local law.

Revised: 12/99, 4/02, 5/05, 9/05, 11/05

SECTION 2. MEDICAL RECORDS

2.1 General

a) The admitting practitioner shall be designated as the attending practitioner unless an order is written at any time during the hospitalization for another practitioner to assume care of the patient.

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. All patient medical record entries must be dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Its contents shall be pertinent and current.
Rev 09/2009

b) This record shall include: Identification data; complaint; appropriate consents; personal history; physical examination; admitting and final diagnosis; notes, documentation, records, reports, recordings, test results, assessments, including documentation of complications, hospital acquired infections, unfavorable reactions to drugs and anesthesia, patient reported allergies; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed.

The medical record should contain sufficient information to:

- Justify admission;
- Justify continued hospitalization;
- Support the diagnosis
- Describe the patient's response to medications; and
- Describe the patient's response to services such as interventions, care treatments, etc.

(Rev 11/09)

2.2 History and Physical

a) A complete admission history and physical includes the following components and documents justification for the medical necessity for admission, continued hospitalization or services rendered:

- Chief Complaint
- Details of present illness
- Relevant past, social & family history
- Inventory of body systems
- Current Medications
- Relevant physical examination including mental status

Based upon the H&P, the following is also documented:

- Statement on the conclusions or impressions or diagnoses drawn from the H&P

- Statement on the course of action planned for this episode of care

b) A complete admission history and physical including all updates:

- Is completed by a physician, an oral-maxillofacial surgeon or other qualified individual in accordance with State law and hospital policy/privileges. If an H&P is completed prior to admission by a practitioner who is not a qualified medical staff member, a qualified physician/practitioner must authenticate/attest the H&P and any updates as in 'c' below.

- Is in the medical record within 24 hours of admission to inpatient or outpatient observation status. If the H&P is dictated and therefore may not make it to the chart within 24 hours, there must be a note in the chart saying that the H&P was performed and dictated.

- Is in the medical record prior to surgery. When an H&P is not in the record prior to surgery, a brief admission note, including an omission explanation statement plus the patient's heart rate, respiratory rate and blood pressure, is documented prior to surgery.

- Is in the medical record prior to admitting outpatient elective labor inductions

- Is in the medical record prior to labor induction for medically indicated inductions

c) The H&P may be completed within 30 days prior to admission or surgery. H&Ps dated more than 30 days may not be accepted or attested to or annotated; a new document must be created. If the H&P is completed prior to admission/surgery, or for a readmission with the same or related problem, the H&P is updated within 24 hours of admission but before surgery. The physician/practitioner may attest the H&P by signing and dating it or entering a concur progress note. The physician/practitioner signature and date attests to the following:

- the H&P and any updates have been reviewed
- a second assessment has been conducted to confirm the information and findings
- any changes in information, findings and physical/psychosocial status is entered as an update note as necessary to assure a complete and current H&P.

(rev. 12/2010)

e) Approved obstetrical prenatal records may be utilized as the admission H&P for obstetrical patients. If a physician/practitioner chooses to use prenatal records as the H&P:

- they should be sent to the OB department no later than the 38th week of gestation
- any changes in information, findings and physical/psychosocial status is entered as an H&P addendum to assure a complete and current H&P.

f) Physician members of the Consulting Medical Staff and oral or maxillofacial surgeons who have been granted such privileges have the option of providing a complete H&P themselves or deferring to a member of the Active Medical Staff. In the case of the later, the consultant provides a consultation report regarding the current, specific problem resulting in the admission or surgery.

g) Podiatrists (DPM) may perform pre-operative history and physicals for their patients, who meet ASA criteria I or II only. Patients with ASA of III or greater must have an H&P done by an active medical staff member. If a podiatrist needs to admit their patient, consult must be obtained from a member of the active medical staff.

h) Dentists document the H&P exam relevant to their respective fields. A complete admission H&P is provided by a member of the Active Medical Staff.

2.3 Progress Notes

a) Pertinent progress notes are recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes contain documentation to justify medical necessity for continued stay or service rendered. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

b) Progress notes are written daily after the attending Medical Staff member has physically seen the patient, except in the case of true telemedicine. Rev. 09/2009

c) When progress notes are documented by a physician assistant, the attending physician documents a review of the notes every third day.

2.4 Operative Reports

a) Operative reports include:
- Name and hospital identification number of the patient
- Date and times of the surgery
- Pre and post operative diagnoses
- Name of the specific surgical procedure(s) performed
- A description of techniques, findings, and tissues removed or altered
- Name(s) of the surgeon(s) and assistant or other practitioners who performed surgical tasks (even when performing those tasks under supervision)
- Type of anesthesia administered
- Complications, if any
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissue)
- Prosthetic devices, grafts, tissues, transplants, or devices implanted

b) Operative reports are written or dictated immediately following surgery.

c) Due to transcription delays, a written operative progress note is entered in the medical record immediately following surgery. The operative progress note contains the same elements as in 2.4a, in a summary format

2.5 Procedure Notes

a) Procedure notes shall be required to document any procedure performed in the hospital including but not limited to: closed reduction of fracture; epidural steroid injection; any endoscopy; central or arterial line placement, intubation, tracheotomy, etc. These notes shall be documented immediately following the procedure.

b) Procedures involving the use of local anesthesia shall require reports to be documented immediately following the procedure, and shall include the indication for the procedure, pertinent physical findings, and a description of the procedure performed.

2.6 Consultation Reports

a) Consultation reports shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

b) When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the medical record, be recorded prior to the operation. This includes cesarean sections.

2.7 Authentication (Rev. 07/11; 04/15/10)

a) All clinical entries and attestations in the patients medical record are accurately dated, timed and authenticated by written or electronic signature or identifiable initials. Rev. 09/2009

b) Practitioner participating in the Electronic Signature program by signing the Physician Reports Agreement. This Agreement applies only to dictated reports meeting the requirements of the Agreement. After the finalized implementation of an Electronic Medical Record System, all providers are required to utilize the Electronic Signature system.

2.8 Abbreviations and Symbols

An official list of “DO NOT USE ABBREVIATIONS” will be maintained on the Hospital’s Intranet system. There is a suggested list of abbreviations available on the Hospital Intranet system.
(Rev. 07/11)

2.9 Discharge Summary

a) Discharge summaries shall include: the reason for hospitalization; significant findings; procedures performed and treatment rendered; instructions on discharge regarding diet, medication, physical activity limitations and follow-up care, final diagnosis and~~,~~ condition on discharge stated in terms permitting specific measurable comparison and not in subjective terms such as "improved". (Rev. 02/10)

b) When applicable, a Death Summary must be completed on all patients.

c) For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of the hospitalization, the case disposition, and any provision for follow-up care. (Rev 07/11)

2.10 Confidentiality of Medical Records

a) Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

b) Any practitioner involved in the care and treatment of a patient shall be allowed to review that patient's medical record at the hospital. Treating practitioner will receive copies of all dictated reports, reports of diagnostic studies, etc. Because of the patient-hospital privilege, the hospital does not have the authority to give the practitioner a copy if the patient's entire medical record without a signed authorization from the patient.

c) Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital.

d) Removal of medical records from the hospital is grounds for suspension of the practitioner for a period to be jointly determined by the Hospital Chief Executive Officer and the Medical Staff Executive Committee.

e) In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.

f) Free access to all medical records of all patients shall be afforded to members of the medical staff or allied health professional staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Staff Executive Committee before records can be studied. Subject to the Hospital Chief Executive Officer, former members of the medical staff or allied health professional staff may be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

2.11 Physician Orders

a) All orders for treatment are in writing, justify medical necessity, are signed, dated, and timed by the attending practitioner when required. (See 3.2, a) through g)). (Rev. 09/2009)

b) A practitioner's protocols/pre-printed orders, when applicable to a given patient, shall be included in the patient's medical record and signed, dated, timed utilizing hospital standards, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. All physician orders shall be timed, as with restraints. See 3.2a-h. (Rev 4/03; 09/2009; 02/2010)

c) Protocols/pre-printed orders are approved initially and reviewed bi-annually by the appropriate Medical Staff Department with final approval by the Medical Executive Committee. (Rev 02/10)

2.12 Record Completion and Filing

a) The patient's medical record should be complete at time of discharge, including progress notes, final diagnosis, operative reports, procedure reports, and discharge summary. A medical record is considered complete if it contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment and services; document the course and results of care, treatment and services; and promote the continuity of care among providers.

- b) **Timely Completion of Medical Records.** Documentation in the medical record is in accordance with timeliness requirements of the Center for Medicare and Medicaid Services Conditions of Participation (CMS CoP) and/or State Law.

(Rev. 12/2010)

c) The Medical Records Department monitors timeliness of documentation and notifies the practitioner of incomplete/delinquent medical records. An incomplete medical record is defined as a chart less than 30-days-old post discharge. A delinquent record is defined as a medical recordthat is older than 30-days post discharge. All incomplete medical records must be completed within 30 days of discharge or outpatient care, containing a final diagnosis per CMS CoP §482.24(c)(2)(viii). A Query/Inquiry placed on a medical record is part of the permanent medical record and must be answered by the practitioner within this 30-day time period.

Practitioners who have records older than 30 daysmay be temporarily suspended until all available records are complete. Temporary suspension of privileges is carried out by notifying the practitioner and the appropriate departments. Enforcement of this policy shall be the joint responsibility of the hospital Chief Executive Officer and the Chief of Medical Staff, or designee(s). Practitioners with frequent or prolonged suspensions for delinquent medical records shall be subject to further disciplinary action by the Medical Executive Committee. Medical Records suspensions greater than 30 days are required to be reported to the National Practitioner Data Bank (NPDB).(Rev. 12/2010)

If a practitioner is to be unavailable for five (5) or more working days, he or she

should notify Medical Records, prior to the period of unavailability, and complete all available charts.

d) A medical record shall not be permanently filed until it is completed by the responsible practitioner except upon order of the Medical Staff Executive Committee.

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Revised: 8/93, 5/96, 8/96, 12/96, 5/9, 1/00, 2/00, 8/01, 3/02, 4/02, 7/02, 8/02, 1/07, 11/09; 07/11

SECTION 3. GENERAL CONDUCT OF CARE

3.1 Consents

A. A Conditions of Admission form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. This shall serve as general consent for examinations, procedures and treatment rendered the patient under the general and special instructions of the physician.

B. An informed consent should be obtained by the physician from the patient or patient's legally authorized representative prior to the performance of any invasive procedure or procedure that puts the patient at risk for harm or adverse outcome and such consent should be documented in the patient's medical record. (see also 4.4,c)

C. Written, informed consent must be obtained by the physician before an HIV-related test can be ordered or performed. If the person is not competent to provide consent, consent must be provided by their legal representative (a protected person's parent or guardian or an individual holding a medical power of attorney).

EXCEPTIONS: See Laboratory Department's General Policy Manual; Section on HIV Testing, OR Arizona Consent Manual, Chapter 4.

3.2 Physician Orders

A. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to authorized personnel and signed, dated and timed by the attending physician. Persons authorized to receive verbal or telephone orders are:

1. Registered Nurses (RN) or Licensed Practical Nurses (LPN)
2. Registered Pharmacists
3. Respiratory Therapists (for R.T.)
4. Physical Therapists (for P.T.)
5. Registered Dietitian (for diet orders including tube feedings and TPN) or designee (for diet orders and nutrition supplements only).
6. A.R.R.T. (For diagnostic imaging)
7. C.N.M.T. (For nuclear medicine)
8. M.T. (For lab procedures)

Rev. 09/2009

B. Verbal and telephone orders can be taken only from:

1. A Physician
2. A Physician's Assistant, under a physician's direction
3. A Registered Nurse, Nurse Practitioner or Licensed Practical Nurse under a physician's direction

C. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order or enter it into a computerized order entry system (if such system exists) without delaying of

treatment. Verbal orders should be recorded directly onto an order sheet in the patient's medical record or entered into the computerized order entry system, if applicable. The content of verbal orders must be clearly communicated, and nationally accepted read-back verification practice to be implemented for every verbal order. Verbal and telephone orders shall be signed, dated and timed by the receiver of the verbal order, with the name of the physician, physician's assistant, or registered nurse dictating the order, per his or her own name. Whenever possible, the receiver of the order should write down the complete order or enter it into a computerized system, then read it back, and receive confirmation from the individual who gave the order.

The physician should sign, date and time such orders within 48 hours. A qualified licensed practitioner, such as a physician assistant (PA) or nurse practitioner (NP), may authenticate a physician's or other qualified license practitioner's verbal order only if the order is within his./her scope of practice and the patient is under his/her care.

If the ordering practitioner is unable to authenticate his or her verbal order (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time), it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner, provided the ordering physician has written an order for another practitioner to assume care of the patient.. When a practitioner other than the ordering practitioner signs a verbal order, that practitioner assumes responsibility for the order as being complete, accurate and final. (Rev. 04/15/10)

Verbal orders are orders for medications, treatments, interventions or other patient care that are transmitted as oral, spoken communications, delivered either face-to-face or via telephone.
Rev. 09/2009

D. All practitioners' orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the person responsible for carrying out the order.

E. Standing orders and protocols may be formulated by individuals or Medical Staff committees and must be approved by the appropriate standing Committee and the Medical Executive Committee. All such orders and protocols shall be reviewed annually by the appropriate committee.

F. All medications on stop-order will be discontinued at the end of the stop-order period if they have not been reordered and if the attending physician has been notified.

*G. All previous orders are canceled when a patient goes to surgery.

H. The Medical Staff shall adhere to the Medical Center's policy for use of restraints for voluntary/involuntary immobilization of patients (Organizational-Wide Policy Manual, Chapter II: Patients Rights/Organizational Ethics, Section 1.4 Guideline for Use of Restraints). Added 09/2009

I. In regards to attestation statements, the individual who authored a medical record entry is the only individual allowed to provide an attestation statement related to the same medical record entry. As such, a member of an ordering physician's call group or an ordering physician's partner may only provide an attestation statement if such member or partner authored the medical record entry related to the attestation statement.

Added 04/15/10

3.3 Drug/Medication Orders

A. All medications on stop-order will be discontinued at the end of the specified time if they have not been re-ordered and after the physician has been notified.

B. All controlled substances, II through V, are required to be re-ordered every three days (72 hours).

C. All antibiotics are required to be re-ordered every seven (7) days.

D. Drugs used shall be those that meet the standards of the United States Pharmacopeia/National Formulary. Exceptions to this rule shall be well justified and approved by the Pharmacy & Therapeutics Committee and the Medical Staff Executive Committee.

3.4 Investigational Drugs

A. Investigational drugs must be approved by the Pharmacy & Therapeutics Committee and the Medical Staff Executive Committee.

B. Use of investigational drugs shall be in accordance with approved pharmacy policy.

3.5 Consultations

A. It shall be the responsibility of the attending practitioner to request consultations when indicated. Except in an emergency, authorization for a consultant to examine a patient shall be provided by the attending practitioner as an order in the patient's medical record. The order shall indicate what responsibilities the consultant is to assume;
1) Consult;
2) Consult and assume care of patient.

B. Consultation with a member of the Active or Consulting Medical Staff shall be required:
1) When requested by the patient or patient's family.
2) When consultations are a condition or modification of delineated privileges.

C. Consultations are recommended in the following instances:

1) When the patient is not a good risk for operation or treatment;

2) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
3) Where there is doubt as to the choice of therapeutic measures to be utilized;
4) In unusually complicated situations where specific skills of other practitioners may be needed;
5) In cases in which the patient exhibits psychiatric symptoms;

D. The Specialty Call Schedule is to be utilized to identify which specialist is available for consults for the Emergency Department and inpatients. In addition to providing coverage to the Emergency Department, physicians on call per the Specialty Call Schedule must also be available for inpatient consults.

E. Consultations are to be completed within twenty-four (24) hours unless otherwise determined by the providers involved. The expectation is that the consultation be done physician to physician. Added 09/2009; Rev. 12/2010

3.6 Reportable Deaths and Autopsies

A. According to Arizona law A.R.S. 11-593, the following types of deaths are reported to the nearest peace officer:

- Death when not under the current care of a physician for a potentially fatal illness or when an attending physician is unavailable to sign the death certificate;
- Death resulting from violence;
- Death occurring suddenly when in apparent good health;
- Death occurring in a prison;
- Death of a prisoner;
- Death occurring in a suspicious, unusual or unnatural manner;
- Death from a disease or accident believed to be related to the deceased's occupation or employment;
- Death believed to present a public health hazard;
- Death occurring during anesthetic or surgical procedure
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If the death is reported, the family is contacted when possible. The autopsy is performed as determined by the medical examiner.

B. The following autopsy guideline criteria from the College of American pathologists assists physicians as to when to consider and autopsy:

- Unanticipated Death;
- Death occurring while patients is being treated under an experimental regime;
- Intraoperative or intraprocedural death;
- Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
- Death incident to pregnancy or within 7 days following delivery;
- All deaths on the psychiatric service;
- Death where the cause is sufficiently obscure to delay completion of the death certificate;
- Death in infants/children with congenital malformations.

If the physician requests the autopsy, he/she obtains consent or refusal from the next of kin and documents such in the medical record.

C. Autopsies may be requested by the next of kin. If the family requests the autopsy, the physician is notified.

D. Autopsy reports are used as a source of clinical information when performing death chart reviews or other quality improvement activities. When appropriate, educational programs are designed to highlight findings that impact the quality and appropriateness of patient care.

Revised: 8/93, 2/95, 11/95, 8/96, 1/97, 6/99, 7/99, 4/02

SECTION 4. RULES REGARDING SURGICAL CARE

4.1 Scheduling

A. Routine operating hours are 7:30 a.m. to 7:00 p.m., Monday through Friday (excluding holidays).

B. Elective scheduling is done by the O.R. Scheduler 7:00 a.m. to 7:00 p.m., Monday through Friday.

C. Emergency surgery may take priority over a regularly scheduled elective case and will be scheduled with the O.R. Scheduler. If time permits, the physician "bumping" the schedule with his emergency operation should notify the surgeon of the elective case. Only in dire emergencies will the O.R. Scheduler assume the responsibility of notifying the "elective" surgeon. The emergency patient should be seen by the surgeon prior to bumping an elective patient. Anesthesia will be notified of emergency surgery by O.R. personnel

D. Operating Room, anesthesia and PACU personnel are on-call evenings, weekends and holidays for emergency or urgent procedures only. The urgency of the procedure is to be determined and documented by the physician. Emergency or urgent surgery occurring outside the routine operating time will be scheduled by the Administrative Shift Coordinator or designee who will notify the on-call operating room and anesthesia personnel of pertinent information.

E. In cases of conflicting emergency or urgent surgery cases, priority will be determined by the surgeons and the anesthesia provider.

F. Anesthesia coverage is to be arranged by the surgeon.

G. Surgical assistance, if required, is to be arranged by the surgeon.

H. Pathology services needed during surgery are to be arranged by the surgeon and scheduled as early as possible in the day.

I. Radiology services for routine elective surgery are arranged by the O.R. Clerk. Emergency radiology services during surgery are arranged by O.R. personnel.

J. Information for scheduling surgery shall include:
1. Patient's name, age and sex
2. Surgeon and assistant
3. Diagnosis
4. Operative procedure planned
5. Special instrumentation/instructions
6. Anesthesia provider desired

K. Patients scheduled for surgery shall be admitted no later than one and one-half (1/2) hours prior to the posted time of surgery.

L. Cell saver services, if required, are to be arranged by the surgeon.

4.2 Major Surgery

A major surgery is any procedure involving an opening or entering into a sterile cavity (peritoneum, pleura, or pericardium), any major joint prosthetic implant, or any procedure having a significant risk of morbidity or mortality.

4.3 Surgery Requiring an Assistant

Surgery assistants will be required at the discretion of the surgeon.

An assistant must be a physician or other qualified credentialed individual who is granted privileges to first assist in surgery.

4.4 Surgical Consents

A. A surgical procedure shall be performed only on consent of the patient or the patient's legal representative. (see also 3.1,B)

B. Written consents are strongly preferred. Whenever a procedure involves significant risks, the need to administer blood or blood components, general anesthesia, or possible dispute concerning the patient's agreement, the physician must document in the medical record that the risks, consequences and alternatives have been explained to the patient, and that the patient understands and agrees to the procedure. When verbal consent is obtained, the physician must document in the medical record that the risks, consequences and alternatives have been explained to the patient, and that the patient understands and agrees to the procedure.

C. It is the responsibility of the operating physician to obtain informed consent from the patient. The physician or office personnel shall complete the proposed procedure, name of surgeon, date and time on the consent form. Hospital personnel may witness the patient's signature on the consent form.

D. The surgical consent form should be used in emergencies if the patient or the patient's legally authorized representative is able to sign. When a signature cannot be obtained, the "Physician's Certificate of Emergency and Necessity" form should be used.

4.5 Surgery Start Time

Start time is 7:30 a.m., Monday through Friday (except holidays). Surgeons should be in the O.R. suite and ready to commence surgery immediately prior to induction of anesthesia. Failure to begin surgery within a reasonable time after the scheduled start time may result in rescheduling of the procedure to a later time.

4.6 Routine Pre-operative Checks

Pre-operative checks by the O.R. staff shall include:

1. Patient identification & allergies
2. History and physical report
3. Laboratory reports
4. EKG report
5. Consents
6. Consultation reports, if indicated
7. Verification that pre-op meds were given

4.7 Pre-operative Orders

A. All pre-op orders shall be recorded on the physician's order sheet. (see also 3.2, a)

B. All previous physician's orders shall be canceled when a patient goes to surgery.

4.8 Pre-operative Laboratory Work

Pre-operative laboratory work shall be current as determined by the surgeon and the anesthesia provider. (See also Section 5.7).

4.9 Pre-operative Diagnosis

The surgeon shall record and sign a pre-operative diagnosis prior to surgery.

4.10 Verification of Surgical Privileges

Verification of privileges to perform scheduled procedures shall be the responsibility of the Assistant Director of Nursing for the O.R. or a designee.

4.11 Tissue Requiring Pathological Examination

A. It shall be the responsibility of the surgeon to see that all specimens removed during surgery, which require pathological examination, are sent to the pathologist.

B. Tissue removed at surgery will be sent to pathology in accordance with the hospital's policy as approved by the Medical Staff. (Rev 8/07; 02/10)

C. The ordering physician and pathologist shall determine which tissue specimens require a gross and/or microscopic examination in an effort to establish a definitive diagnosis. (Rev. 02/10)

4.12 Dental and Podiatric Surgery

Dental and podiatric surgery is under the general supervision of the physician advisor of the Surgery Department.

4.13 Surgical Equipment

Verification of the physical presence of all equipment necessary for a given procedure, prior to the onset of anesthesia, is a primary responsibility of the operating surgeon. Ordering equipment will not substitute for verifying its arrival in the operating room.

4.14 Surgical Deaths

Deaths occurring in the surgical department are automatically classified as coroner's cases pursuant to A.R.S. 11-596.

4.15 Recovery Room

A. Routine recovery room hours are 8:00 a.m. to 10:00 p.m., Monday through Friday (except holidays).

B. After routine hours, recovery will be accomplished by the on-call P.A.C.U. nurse.

C. Patients are discharged from PACU by a Licensed Independent Practitioner or according to criteria developed and approved by the medical staff.

Revised:10/93, 6/95, 1/97, 2/97, 5/98, 3/00, 10/06

SECTION 5. RULES REGARDING ANESTHESIA CARE

5.1 Anesthesia Coverage

Continuous anesthesia coverage will be provided for surgical and obstetrical services.

5.2 Pre-Anesthesia Evaluation

Every patient will have a pre-anesthesia evaluation done by a licensed anesthesia provider. Except in emergencies, this evaluation should be recorded before pre-operative medication is administered and should include choice of anesthesia, the contemplated procedures, the patient's previous drug history, other anesthetic experiences, and any potential anesthesia problems.

Immediately preceding the administration of conscious sedation drugs, a re-evaluation is documented.

5.3 Pre-Induction*
Equipment and Supplies Check*
Anesthesia Record*
Post-Op Responsibility*

*Refer to Anesthesia Department Policy/Procedure Manual

5.4 Anesthesia Agents Permitted in Hospital

Only non-flammable anesthetic agents shall be permitted for use in the hospital.

5.5 Anesthesia Agents Permitted in Delivery Room

Anesthetic agents permitted to be used in the delivery room are narcotics, tranquilizers, and local anesthetic agents via any route deemed appropriate by the anesthesia provider.

5.6 General Anesthesia in Delivery

General anesthesia may be administered in the delivery room by anesthesia staff, only when all O.R. suites are occupied, and providing appropriate staff, equipment and monitors are available.

5.7 Pre-Operative Guidelines for Anesthesia Services

Preoperative guidelines for Anesthesia Services are as follows:

A. Elective outpatient cases should be scheduled by 1300 when possible.
B. All pediatric and diabetic patients should be done in early morning when possible.
C. When a surgeon schedules multiple cases during the day, priority should be given to pediatric patients, diabetics, and outpatients in that order.

5.8 Conscious Sedation

Prior to conscious sedation procedures, a pre-sedation assessment is completed by the credentialed physician, CRNA, or licensed independent provider. Immediately preceding the administration of conscious sedation drugs, a re-evaluation assessment is documented, At a minimum the assessment components include the following:

- pre-existing cardiac or pulmonary disease
- previous experience with sedation/analgesia
- physical evaluation to include cardiac and respiratory status
- oral airway evaluation
- anesthesia/sedation plan
- ASA classification

D. Preoperative routine laboratory screening for otherwise healthy patients in various age categories is as follows:

AGE	
Under 50	HB or HCT Only if indicated
Over 50	EKG (excl. Outpatient procedures under local IV sedation unless indicated)

Other labs if indicated per patient's medical history/condition.

E. The referring physician may obtain any lab considered necessary, allowing sufficient time for results to be considered pre-operatively. Often patients not in the "healthy" category will require additional preoperative laboratory workup; this will be at the discretion of the referring physician or the anesthesia provider.

F. Routine use of CBC and UA will be at the physician's discretion.

G. Preoperative laboratory values are acceptable for 14 days. EKGs are acceptable for six (6) months.

Revised: 8/96, 8/98, 2/00, 6/00, 4/02

SECTION 6. RULES REGARDING OBSTETRIC/NEWBORN CARE

6.1 Standard of Care

A. All physicians will provide obstetric and newborn care within the limits of their approved delineation of privileges. Patients requiring care the physician is not privileged to provide will require consultation and/or referral.

B. Responsibility for obtaining required consultations is that of the attending physician or nurse midwife.

C. Practitioners must have current certification in neonatal resuscitation in order to be granted the privilege of attending the newborn at high risk deliveries.

6.2 Maternal/Neonatal Transport

A. Infants needing specialty care and/or services not available at Summit Healthcare will be transferred to an appropriate facility as soon as possible.

B. Federal law places strict requirements on transfers of women in labor by hospital that receive Medicare funding. The following procedures must be followed:

1) Determining whether a patient has an emergency medical condition. The statutory definition is as follows: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention can reasonably be expected to result in placing the health of the individual in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The health of the fetus must also be considered in determining whether an emergency medical condition exists.

2) Special determination of emergency medical condition of a pregnant woman. The statutory definition also makes specific reference to pregnant women. It provides that an emergency medical condition exists if a pregnant woman is having contractions and (a) there is inadequate time to effect a safe transfer to another hospital before delivery; or (b) transfer may pose a threat to the health or safety of the woman or the unborn child. An emergency medical condition does not exist unless the woman meets one of the two above criteria in addition to having contractions.

3) Pregnant women meeting the criteria for an emergency medical condition. If it is determined that a pregnant woman is having contractions and meets either of the two other criteria for an emergency medical condition noted above, the physician may either provide treatment to stabilize her condition - which means delivering the fetus and placenta - or may effect her transfer to another medical facility in accordance with specific procedures as outlined below.

4) Procedures to follow for transferring a pregnant woman to another medical facility. The patient may request a transfer in writing after being informed of the hospital's obligations under the law and of the risks of a transfer. A patient may also be transferred to another medical facility without having requested a transfer provided that the following conditions are met: A physician must certify in writing that based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweighs the increased risk of the transfer poses to the individual's medical condition and that of the unborn child. If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person may sign the certification described above after consultation with a physician who authorizes the transfer provided that the physician later countersigns the certification.

Receiving hospital: The receiving hospital must have space and qualified personnel to treat the patient and must have agreed to accept the transfer. The law provides that specialized facilities, such as neonatal intensive care units cannot refuse to accept patients if space is available.

Transferring hospital: The medical records from the transferring hospital must be sent with the patient and the transfer must be made using qualified personnel and transportation equipment. It is important to note that the medical records must include the informed written consent or certification required by the statute (as discussed above) and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

Hospitals are prohibited from penalizing physicians who, in complying with the law, refuse to transfer patients.

6.3 Labor Rules

A. Induction/augmentation with oxytocin will be administered according to approved OB Department policy #10.2.

B. Prior to initiation of induction of labor, it is recommended that any physician who does not have cesarean section privileges document in the patient's medical record the name of a physician who has agreed to provide coverage should a cesarean section become necessary and the time that physician was contacted.

C. Prostingel for cervical ripening, augmentation/induction will be used only in accordance with approved protocols.

D. Visitors will be permitted during labor with the patient's consent and physician and/or nursing staff approval.

6.4 Delivery Rules

A. Vaginal deliveries will be performed in the delivery room or in labor room #2. Alternative sites for delivery will be:

1. Labor room #1
2. Post partum rooms 2 and/or 3
3. Available post partum beds
4. On a gurney in the labor/delivery hall

B. Elective cesarean sections, sterilizations, and D & C's will be performed in the surgical suite.

C. Emergency cesarean section may be performed in the delivery room only when all O.R. suites are occupied and appropriate surgical staff is available.

D. Anesthetic agents permitted for use in the delivery room are:

1. Narcotics
2. Tranquilizers
3. Local anesthetic agents

E. General anesthetics for high risk mothers should be administered by hospital approved anesthesia personnel.

F. Significant others may be permitted to observe delivery at the discretion of the attending physician and nursing staff.

G. In addition to the delivering physician or surgical team, a physician qualified in neonatal resuscitation should be present for the following delivery situations:

1. Gestational age less than 36 weeks
2. Multiple gestations
3. Intrauterine growth retardation (present or suspected)
4. Thick meconium
5. Maternal complications:
   a. Placenta abruption
   b. Hemorrhage, ie; as with placenta previa
   c. Cesarean section for diabetes mellitus of mother
   d. Eclampsia

6.5 Recovery

A. All hospital performed vaginal deliveries will be recovered in the OB Department as their condition permits.

B. The responsibility for post-anesthetic care rests with anesthesia provider.

6.6 Newborn Rules

A. Oxygen and/or other respiratory therapy must be ordered by the attending physician. Oxygen orders shall be stated in percent (%), not liters/minute.

REVISED: 10/95, 5/98

SECTION 7. RULES REGARDING EMERGENCY SERVICES

7.1 Types of Services

A. Emergency services will be rendered any patient presenting at the Emergency Department.

B. Every patient will be assessed by a physician and will receive appropriate emergency treatment.

C. Circumstances under which definitive care will not be rendered will be determined by the attending Emergency Department physician but will include:
1. Severe and extensive burns
2. Neurosurgical cases
3. Severe eye injuries
4. Massive trauma requiring reconstructive surgery
5. Neonates requiring intensive care

D. Outpatient services provided in the Emergency Department include the following:

1. Throat culture
2. Urinalysis
3. Vital signs
4. Medication administration

Patients requiring hospital admission will not be classified as outpatients.

E. Procedures not permitted to be performed in the Emergency Department include:
1. Those requiring general, major regional or spinal anesthesia
2. Elective dilatation and curettage
3. Elective incision and drainage of peritonsillar abscess
4. Colonoscopy and endoscopy (except in emergency situation, i.e. actively bleeding)

F. Anesthesia that IS permitted for use in the Emergency Department includes:
1. Topical anesthesia
2. Local anesthesia
3. Bier block anesthesia
4. Emergent rapid sequence intubation

G. Anesthesia that IS NOT permitted for use in the Emergency Department includes:
1. General anesthesia
2. Spinal anesthesia
3. Major regional blocks, i.e. axillary block

7.2 Physician Staffing

A. All physicians providing Emergency Department coverage must be medical staff members

B. A physician will be on duty 24 hours a day

C. E.R. patients requiring admission must be admitted by a member of the Active Medical Staff.

D. Unless excused by the Medical Executive Committee, members of the Active Medical Staff will provide "on-call" backup coverage, on a rotating basis, for E.R. patients requiring admission or transfer and who do not have a local private physician.

Upon request, Active Medical Staff members may be excused from E.R. call obligation at age 60.

E. Specialist referral and/or consultations will be arranged by the attending Emergency department physician or the patient's local private physician (if he/she is a member of the medical staff). In the event the patient has no local private physician, the "on-call" physician will arrange referrals and/or consultations.

F. Medical direction of the Emergency Department will be provided by the Emergency Department Medical Director.

An Emergency Department/Base Station Quality Assurance Committee chairman will be appointed by the Chief of Staff and will serve as E.D. Physician liaison on the Medical Executive Committee.

7.3 Observation

The E.D. has no observation beds. Patients requiring prolonged observation will be admitted to Outpatient Observation status. (Exception: see Hospital Triage Policy)

7.4 Direct Admits

Patients transported to the hospital by ambulance for direct admission will be screened by the Emergency Department Physician.

7.5 E.D. Medical Records

A. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record if such exists. The record shall include:

1. Adequate patient identification;

2. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
3. Pertinent history of the injury or illness including details relative to first aid or emergency care given prior to arrival at the hospital;
4. Description of significant clinical laboratory and roentgenologic findings;
5. Diagnosis
6. Treatment given
7. Condition of the patient on discharge or transfer; this shall be stated in terms permitting specific measurable comparison, not "improved", "good", etc.
8. Final disposition including instructions given to patient or family regarding necessary follow up care. When relevant, the discharge summary should reflect instructions regarding medications, diet and physical activity.

B. Each patient's Emergency Department record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

7.6 Transfers from the Emergency Department

A. Ability to pay for services shall not be a determining factor in the decision to transfer.

B. If the specialty or level of care required cannot be provided in this hospital, arrangements will be made to refer the patient elsewhere for definitive care.

C. Patients must be stable at time of transfer unless expected benefits outweigh increased risks.

D. Patients may be transferred only upon order of the attending physician or at the request if the patient or patient's family.

E. Documentation of patient transfer must conform with COBRA regulations.

The referring physician is responsible for the patient until the patient is turned over to the Air Ambulance crew for transfer. At such time, the Base Hospital for the Air Ambulance and that Medical Director will be responsible for all orders and directives until the patient reaches the receiving facility.

For purposes of ground transports originating out of Summit Healthcare E.D. and transported by a ground ambulance whose Medical Control is based at Summit Healthcare, the referring physician is responsible for the patient during transport until such time as care is turned over to the receiving hospital.

Reviewed and approved, ER/CC Committee 4/2/91
Revised 10/95, 7/98

SECTION 8. RULES REGARDING SPECIAL CARE UNITS

8.1 Services

The Intensive Care Unit of Summit Healthcare Regional Medical Center provides services to predominately adult patients that require intensive treatment, intensive monitoring, and intensive nursing care. During times of high utilization and scarce beds, patients requiring intensive treatment have priority over monitoring and terminally ill patients. Telemetry monitoring is also provided in the ICU.

8.2 Admission & Transfer Eligibility

It is the responsibility of the attending physician and/or his representative to request ICU admission and to promptly transfer patients meeting discharge criteria.

8.3 Eligibility

Eligibility for ICU admission and discharge is also based upon the reversibility of the clinical problem as well as the likely benefits of ICU treatment and expectation for recovery.

8.4 Patient Priority

A. Priority 3 patients: Critically ill, unstable patients in need of intensive treatment such as ventilator support, continuous vasoactive drug infusion, etc. Examples of such admissions are:

1. Respiratory failure
2. Multiple systems injuries
3. Frank gastrointestinal bleeding
4. Acute/chronic life threatening dysrhythmia

B. Priority 2 patients: Patients who, at the time of admission, are not critically ill but whose condition requires the technologic monitoring services of the ICU. These patients would benefit from intensive monitoring (e.g., peripheral or pulmonary arterial lines) and are at risk for needing immediate intensive treatment. Examples of such admissions are:

1. Acute or underlying heart, lung, or renal disease in patients with severe medical illness or who have undergone surgery.

2. Suicide attempt and/or overdose with potential for self-injurious behavior.

C. Priority 1 patients: Critically ill, unstable patients whose previous state of health, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from ICU treatment. Examples of such admissions are:

1. End-stage metastatic malignancy

2. End-stage heart or lung disease complicated by severe, acute illness.

Priority 1 patients receive intensive therapy to relieve acute complications, but therapeutic efforts might stop short of other measures such as intubation or cardiopulmonary resuscitation.

8.5 Patients Who Do Not Meet Routine Admission Criteria

A. Patients who have confirmed clinical and laboratory evidence of brain death, except those suitable for organ donation.

B. Competent patients who refuse life-supporting therapy including chemotherapy.

C. Patients with irreversible coma.

D. Patients who do not require frequent or continuous monitoring for unstable or potentially unstable illness.

8.6 Transfers

1. Transfers to another facility may be required if the patient has the need for specialties or services not offered at Summit Healthcare, or by request of the patient or family members.

2. Patients eligible for transfer from ICU to another unit in the hospital are those who no longer require the intensive care services. Cardiac monitoring may be continued off the unit via telemetry monitoring. (For specific transfer criteria, see ICU policy #1.1)

3. All previous physicians' orders are cancelled when a patient is transferred either from the ICU to another unit in the hospital or into the ICU from another unit in the hospital.

(Rev. 11/09)

8.7 Discharges

Discharge from the ICU should be considered an unusual event. Discharge is acceptable for those patients in which a diagnostic work-up has shown no evidence of acute disease that requires further hospitalization. These patients must meet adapted ISDA discharge screening criteria specific for their diagnosis, as determined by the patient's physician. (For specific discharge criteria, see ICU policy #1.1)

8.8 Standing Orders and Protocols

Standing orders and/or protocols for use in ICU will be approved by the Medical/Critical Care Committee and the Medical Executive Committee. When used, they must be signed, dated and timed by the physician initiating the orders. Rev. 09/2009

8.9 Medical Standards

A. Medical staff members admitting patients into special care units will have the appropriate credentialed privileges to care for their patients or they will consult with a physician with the appropriate privileges. If a patient is in need of specialized medical services and there is no physician with the appropriate skills/privileges available on staff, the patient will be referred/transferred to a physician with the appropriate skills/privileges.

B. When a physician asks another physician to "cover" or "take call" for him, that physician must have the appropriate privileges/skills to care for his patients.

C. All patients entering or leaving the ICU will have met the criteria outlined in the ICU Admission/Discharge/Transfer Criteria. (Refer to ICU Policy, #1.1).

D. All patients in ICU will be seen by their admitting physician within twelve (12) hours of admission. Initial evaluation in the office, ER, or Cath Lab is counted as a visit. Patient must be seen earlier as circumstances dictate. (Rev 10/07)

E. Responsibility for obtaining consultation is that of the attending physician. Requests for a physician consult will be arranged from physician to physician and documented in the physician orders. Nursing personnel will assist with obtaining non-physician consults.(See also 2.6 & 3.5)

F. Each ICU patient will be seen at least once each 24 hours by the admitting and/or consulting physician.

G. The patients in ICU will be under the care of an attending physician who has appropriate privileges to monitor the care being provided to them. The Emergency Department physician will respond to emergencies within the Intensive Care Unit and the patient’s attending physician, or an appropriate on call physician covering, will respond promptly to the unit to take over the care of the patient.

Revised: 11/95, 5/98, 3/00

SECTION 9. DISASTER PLAN RULES

9.1 Disaster Plan

A plan for handling mass casualties and illnesses shall be developed by a multi-disciplinary committee with medical staff and hospital representation, and approved by the Medical Staff Executive Committee.

9.2 Medical Staff Disaster Drill Assignments

Staff physicians will be asked to participate periodically in disaster drills and will be assigned to posts, either in the hospital, or in designated casualty stations. It is the physicians' duty to report to their assigned stations.

9.3 Medical Authority

A. All policies regarding patient care will be a joint responsibility of the Medical Disaster Officer, the Chief of the Medical Staff, and the CEO or designated administrative representative on the scene.

B. In the event of a disaster, the following responsibilities will be assigned:

1. Medical Disaster Officer. Will be the Physician on duty in the Emergency Department at the time the Code D is activated. This physician is responsible for the assignment of all available physicians to treatment areas. The Medical Disaster Officer position may be assigned to any appropriate physician as deemed necessary by the E.D. physician, to enable the E.D. physician to care for patients already in the department.

2. Triage Officer. The back-up Emergency Physician and/or Triage RN on duty will be the Triage Officer. The Triage Officer evaluates incoming patients, decides on their disposition, and communicates the need for additional Triage staff to the Medical Disaster Officer.

3. The Chief of the Medical Staff may be asked to evaluate in-house patients and coordinate with the patient's physician for possible discharge so as to allow for more efficient use of staff and facilities.

C. All physicians on staff of the hospital specifically agree to relinquish direction of the professional care of their patients to the Medical Disaster Officer or designee.

D. Triage Physician responsibilities shall be to:

1. Organize the triage area

2. Briefly evaluate all incoming victims and assign them priority designations.

3. Authorize discharge or transfer of inpatients if such is deemed necessary to accommodate disaster casualties.

Reviewed and approved, ED/Base Committee 3/13/96

SECTION 10. THE DISRUPTIVE PHYSICIAN

10.1 Definition of Disruptive Conduct:

A. Attacks leveled at other appointees to the medical staff which are personal, irrelevant, or go beyond the bounds of fair professional comment.

B. Refusal to accept medical staff assignments, or to participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner.

C. Abusive behavior to patients, yelling at them or refusing to listen to their legitimate questions and requests.

D. Imposing idiosyncratic requirements on nursing staff which have nothing to do with better patient care but serve only to burden the nurses with "special" techniques and procedures.

E. Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence.

F. Impertinent and inappropriate comments written (or "cute" illustrations drawn) in patient medical records or other official documents impugning the quality of care in the hospital or attacking particular physicians, nurses, or hospital policy.

G. Rude behavior to visitors and other hospital personnel, "justified" by the physician's busy schedule and the "unreasonable" demands placed on him.

H. Repeated occurrences (six or greater occurrences in a two year re-appointment cycle) in which the physician does not respond to calls or pages within the thirty minute time standard.

10.2 Medical Staff Policy Regarding Disruptive Conduct

A. Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies disciplinary action, but rather a pattern of conduct. That Documentation shall include:

1. the date and time of the questionable behavior;
2. if the behavior affected or involved a patient in any way, the name of the patient;
3. the circumstances which precipitated the situation;
4. a description of the questionable behavior, limited to factual, objective language as much possible;
5. the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
6. record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

B. The report shall be submitted to the Chief of the Medical Staff and then forwarded to the Chief Executive Officer of the hospital.

C. If the single incident warrants a discussion with the offending physician, the Chief of the Medical Staff shall initiate that and emphasize that such conduct is inappropriate.

D. If it appears to the Chief Executive Officer and/or the Chief of Staff that a pattern of disruptive behavior is developing, one or both shall discuss the matter informally with the physician.

1. The initial approach should be collegial and designed to be helpful to the physician.
2. Emphasize that if the behavior continues, more formal action will be taken to stop it.
3. Informal meetings shall be documented.
4. A follow up note to the physician shall state that the physician is required to behave professionally and cooperatively.

E. If such behavior continues, the Governing Board Chairman or one acting on the Chairman's behalf shall meet with and advise the physician that such conduct is intolerable and must stop. This meeting is not a discussion, but rather, constitutes the physician's final warning. It shall be followed with a letter reiterating the warning. That letter becomes a part of the physician's permanent file.

F. A single additional incident shall result in initiation of formal disciplinary action pursuant to the Medical Staff Bylaws.

SECTION 11. SEXUAL HARASSMENT BY A PHYSICIAN

11.1 Procedure to Investigate a Complaint of Sexual Harassment by a Physician

If any individual working in the hospital has observed or been the victim of conduct that constitutes sexual harassment, the following steps should be taken:

A. A written report should be filed with the employee's supervisor who shall forward it to the Chief Executive Officer. The report shall include a factual description of the incident or statement.

B. If, after a discussion with the individual who filed the report it is found to constitute a credible report of conduct that constitutes sexual harassment, the Chief Executive Officer shall share the complaint(s) with the Chief of the Medical Staff.

C. The physician involved shall be required to meet with hospital and medical staff leadership; the Chief Executive Officer and the Chief of the Medical Staff. The physician shall be advised of the complaint(s) and be given an opportunity to respond. If, at the conclusion of that discussion, hospital and medical staff leadership is convinced that the reported acts did occur, the physician shall be advised that such conduct is intolerable and in violation of federal law.

D. The physician should, if appropriate, be given an opportunity to voluntarily cease the conduct that gave rise to the complaint, and to apologize to the individuals involved.

E. A refusal to agree to stop the conduct immediately shall result in a formal warning to the physician that he or she will not be permitted to associate with hospital employees until that agreement is obtained. Thus, the physician shall not be permitted to enter the hospital. That is not a suspension of clinical privileges, even though the effect is the same. The hospital, however, has no choice but to protect its employees from harassing conduct.

F. The matter shall be reported to the Executive Committee of the Medical Staff along with a brief explanation of the circumstances and the applicable federal law.

G. If the individual has agreed to stop such conduct, the meeting shall be followed up with a formal letter of reprimand and warning.

H. Any further reports of harassment, after the individual has agreed to stop the harassing conduct, shall result in exclusion of the individual from the workplace and institution of formal disciplinary action in accordance with the Medical Staff Bylaws.

SECTION 12. PHYSICIAN WELLNESS POLICY

12.1 **Purpose**:

To establish the steps to be taken in the event a Physician is suspected of having a drug, alcohol, psychological, medical or other impairment. This policy creates a process that allows Physician impairment issues to be addressed quickly, appropriately and in a fashion consistent with the best interests of patient care, confidentiality and so as to qualify for peer review immunity under state and federal law.

12.2 **Definitions**:

12.2.1 "Physician" shall mean a physician, dentist or podiatrist who is a member of the Medical Staff.

12.2.2 "Impairment" shall mean the presence of a psychological or physical condition or the usage of drugs or alcohol in a fashion which interferes with a Physician's ability to render safe and appropriate medical care to Hospital patients. Impairment may include, but not limited to, drug or alcohol use or addiction, disruptive behavior, physical illness, aging issues and inappropriate workplace behavior.

12.3 **Process**:

12.3.1 Any individual working in the hospital who has a good faith belief that a Physician is treating Hospital patients while impaired shall immediately contact his or her supervisor. Patients and visitors may notify any employee, who will in turn contact their supervisor. Physicians should contact the unit supervisor.

12.3.2 If the supervisor concurs, the supervisor shall immediately contact the Administrator on call and the Chief of Staff. Additionally, within twenty four (24) hours of the incident, the person raising the concern and the involved supervisor will submit a written report to the CEO and the Chief of Staff, documenting the basis for the allegation, the facts and circumstances which led to the allegation, the names of persons who observed the incident and all other material facts.

12.3.3 The Administrator on call and/or the Chief of Staff will come to the Hospital to meet with the Physician. Pending their arrival, the supervisor will privately request the Physician refrain from treating Hospital patients. The Administrator on call and/or the Chief of Staff will meet with the Physician privately to discuss the allegation and assess the Physician’s condition.

12.3.4 The Administrator on call and/or the Chief of Staff may request the Physician submit to a blood test or urinalysis. The Physician’s refusal to comply with such request will be deemed grounds for immediate investigative suspension. They may also request that the Physician leave the premises, refrain from treating patients for up to forty eight (48) hours under an administrative leave and make appropriate coverage arrangements for the Physician's Hospital patients as a result of such decision. The Administrator on-call and the Chief of Staff will complete written reports within

twenty-four (24) hours of the incident, including their observations, conclusions and the basis for their decision(s).

12.3.5 Where the Administrator on call and/or the Chief of Staff have a good faith basis to believe a Physician was in the Hospital, or otherwise treating Hospital patients, while impaired, they shall immediately contact the chairperson of the Medical Staff Physician Wellness Committee ("PWC").

12.3.6 The PWC will immediately convene a meeting with the Physician. They will renew the written incident reports and use best efforts to meet with the individuals who generated the reports. The purpose of this meeting shall be to conduct a good faith, reasonable investigation of the facts of the situation and to assess the need for referral of the Physician for an evaluation and any related treatment. The Physician shall have the right to see the materials submitted to the MEC.

12.3.7 If in the reasonable belief of the PWC, the Physician requires a psychological, medical or other assessment, the following process will be implemented:

12.3.7.1 The Physician will be required to immediately contact the Arizona State Licensing Board or such other appropriate evaluation program as determined by the PWC for any appropriate evaluation(s) warranted by the circumstances ("Program").

12.3.7.2 The Physician will agree to voluntarily refrain from exercising his or her clinical privileges pending enrollment in, cooperation with and completion of the Program evaluation process, completion of any indicated treatment, receipt of a release to return to practice by the Program and the PWC.

12.3.7.3 The Physician will execute a Physician Support Agreement with the PWC in the same or similar format as that provided in Attachment "A."

12.3.8 If the Physician refuses to cooperate and comply with these steps, the PWC may recommend to the MEC that the Physician be subject to corrective action, including summary suspension, which will entitle the Physician to the rights under the fair hearing plan.

12.3.9 The Program, the Physician will share all information from the Program, including the evaluation and treatment process, requests and recommendations with the PWC. The PWC will meet with the Physician to determine how any treatment prescriptions or recommendations issued by the Program will be implemented, supplemented and/or supported by the PWC. Before resumption of Hospital privileges, the Physician will execute a Physician Assistance Agreement describing this implementation and the relative rights and responsibilities involved. A sample is attached as Attachment "B."

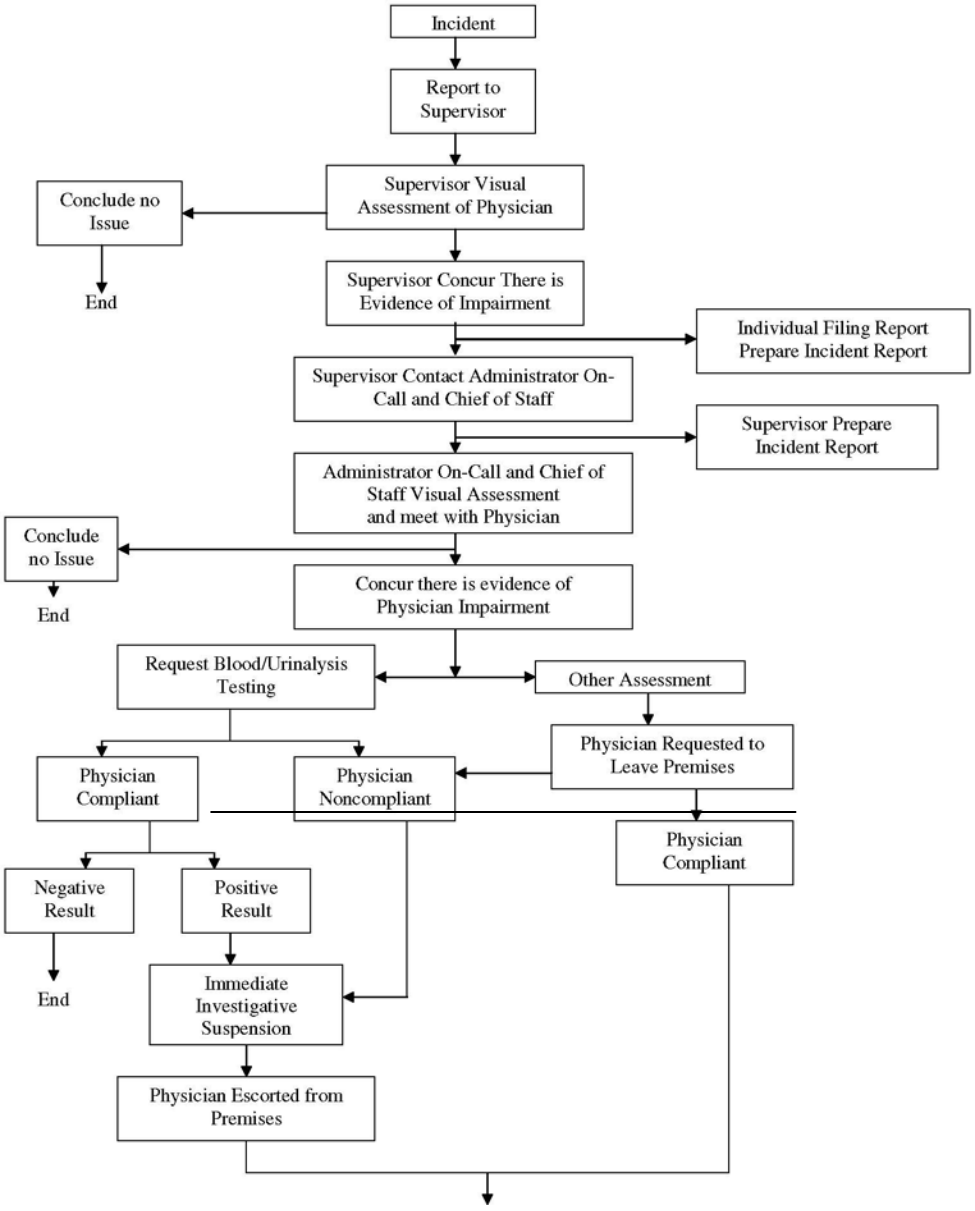
12.3.10 The Medical Staff shall not file a report with the National Practitioner Data Bank or State Medical Licensing Boards regarding Physicians with suspected impairment(s) who cooperate with the PWC and complete the steps outlined in this policy unless

otherwise compelled to do so by applicable law.

12.3.11 Physician Impairment issues, including reports, PWC minutes, test results, Program and PWC documents, shall be treated as confidential and privileged matters, as required by applicable peer review laws.

12.3.12 The Hospital has a zero tolerance policy regarding Physician retaliation against persons who reported suspected Impairment or otherwise participated in the Physician Wellness process as articulated herein. Physicians who retaliate, or who are suspected of retaliating, against such persons may be subject to immediate corrective actions, including but not limited to investigative or summary suspension.

12.4 **Physician Wellness Policy Flowchart**



(Rev. 10/09)

SECTION 13. MEDICAL STAFF PROFESSIONAL CODE OF CONDUCT

The Medical Staff and Allied Health Professional (AHP) Staff of Summit Healthcare shall, through positive behavior and communication, promote honesty, trust, respect and teamwork in order to achieve an environment that fosters quality healthcare.

We value diversity and view this as an opportunity for growth. We will commit to create an atmosphere of respect, compassion, and ethical behavior toward our patients, their families and each other.

It is expected that all members of the Medical Staff and AHP Staff adhere to the Medical Staff Bylaws, Rules and Regulations, Credentialing Procedures Manual, and Hospital policies and procedures (as applicable). This is a summary of expectations that members are expected to follow:

13.1 **Interpersonal Relationships**

- 13.1.1 Conduct actions in a professional and ethical manner at all times toward patients, families, employees, staff members, etc.
- 13.1.2 Communicate respectfully with patients, families and members of the healthcare team
- 13.1.3 Be respectful of the rights, privacy, and cultural diversity of patients, families, and others
- 13.1.4 Address disagreements about patient care or other issues that impact the working environment using conflict management skills promptly, directly, and privately

13.2 **Patient-centered Care**

- 13.2.1 Assume 24-hour responsibility for the inpatient under our care; when off duty, or on vacation, assure that our patients are adequately cared for by another practitioner.
- 13.2.2 When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- 13.2.3 Provide patient care that is professional and within the scope of privileges, education, and training
- 13.2.4 Respond professionally and in a timely manner when called upon by fellow practitioners to provide appropriate consultation or clinical services

13.3 **Safety**

- 13.3.1 Participate in quality measures identified to improve patient safety
- 13.3.2 Participate in the organization's efforts to improve safety from a systems perspective by identifying and reporting potential performance improvement initiatives
- 13.3.3 Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential hospital information

13.4 **Professional Practice**

- 13.4.1 Maintain complete and accurate patient medical records and keep all such information confidential; follow all regulations for release of information

13.5 **Disruptive and Inappropriate Behaviors**

Disruptive Physician and Inappropriate Behaviors (Sexual Harassment) is defined and addressed in the Medical Staff Rules and Regulations.

(Added 04/2009)

SECTION 14. PEER REVIEW POLICY & PROCEDURE

14.1 **Policy Statement**

To ensure that the hospital, through the activities of its medical staff, assesses the ongoing professional performance of individuals granted clinical privileges, used the results of such assessments to improve care, and, when necessary, performs focused performance evaluation.

14.2 Confidentiality, Immunity, and Compliance With State Law:

All written records of interviews, reports, statements, minutes, memoranda, and all physical materials related to research, discipline or medical study utilized in the course of the Peer Review activities described in this policy and procedure is the property of Summit Healthcare Regional Medical Center and it's Medical Staff at the time of the Peer Review and is confidential to the full extent provided by Health Insurance Portability and Accountability Act (HIPAA) and Arizona state law, including, but not limited to, Arizona Revised Statute 36-445.01. (i.e. Peer Review is protected to all but the Federal government, Centers of Medicare and Medicaid Services (CMS), the Arizona Board of Medical Examiners, and the Arizona Board of Osteopathic Examiners in Medicine and Surgery).

Participants in the Peer Review activities described in this policy and procedure who furnish information or opinions related to research, discipline or medical study enjoy immunity from liability to the full extent provided by Arizona state law, including, but not limited to, Arizona Revised Statute 36-445.02.

This policy and procedure is intended to comply with the requirements of Arizona Revised Statute 36-445 for the organization of hospital medical staff peer review.

14.3 Definitions

14.3.1 *Peer Review:* "Peer Review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care and utilization of resources. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information, including 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff, and 3) clinical standards and use of rates in comparison with peers or established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for the personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

14.3.2 *Peer:* A "peer" is defined as a member of the medical staff, in good standing, practicing in the same profession who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance determines what "practicing in the same profession" means on a case by case basis. For example, for quality issues related to general medical care, a physician (i.e., MD or DO) reviews the care of another physician. For specialty-specific clinical issues (e.g., evaluating the technique of a specialized surgical procedure), a peer is an individual who is well-trained and competent in that surgical specialty. *

14.3.3 *Peer Review Body:* The Peer Review Body is designated to perform the initial review by the Medical Executive Committee (MEC). The peer review body is the Quality Initiative physicians, including Summit Healthcare Medical Director, unless otherwise designated for specific circumstances by the MEC. A quorum of 3 physician members of the Peer Review body must be present for Peer Review decisions to be made. If a conflict of interest is present for any member of the Peer Review Body, the physician will be excused. (See definition for Conflict of Interest.) A function of the Peer Review Body is to determine level of technical expertise needed for Peer Review.

For Chief of Staff involvement in peer review, if the Chief of Staff is not available, another officer of the Executive Board of the Medical Executive Committee is called upon to provide direction.

14.3.4 *Early Intervention:* The QM staff may ask the Peer Review Chairman and the appropriate Department Chairman for early intervention with a physician in place of, or in addition to peer review activity when the physician is new to the policies and procedures of Summit Healthcare, the issue is a new issue to a member of the medical staff, or it is deemed that early intervention might keep an issue from escalating into a major problem. The early intervention may be done by the Chief of Staff, the Department Chairman, the Summit Healthcare Medical Director, or combination of as needed. Documentation of an Early Intervention will be reported to the PR Body for informational purposes and will be held in Medical Staff Services. The Early Intervention may be considered at time for reappointment/provisional review.

14.3.5 *Ongoing Professional Practice Evaluation (OPPE)*: OPPE is the routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment and are overseen by the Credentialing Committee

14.3.6 *Performance Improvement Plan (PIP):* PIP activities comprise what is typically called proctoring or focused review, depending on the nature of the circumstances. A PIP is not a formal investigation. Examples of PIP's include the following:

14.3.6.1 Additional education/CME with proof of completion
14.3.6.2 Prospective monitoring/review of next (set by MEC) cases.
14.3.6.3 Second Opinions/Consultations for specific identified issues. Consultant must have appropriate clinical privileges and be acceptable to the Peer Review Body. Consultant must evaluate patient and medical record prior to treatment/procedure.

14.3.6.4 Concurrent Proctoring for identified issues. Proctor must meet Consultant criteria above and must be present at start of case and remain throughout or must personally assess patient and available during course of treatment. The Proctor should intervene if necessary.

14.3.6.5 Participation in formal evaluation/assessment program. Enrollment should be within set time frame and be completed with the time frames set by MEC. A release will be granted for MEC communication with the program.

14.3.6.6 Additional Training in identified area. Program will be approved by MEC and completed by date set.

14.3.6.7 Voluntary refrain from practicing until additional training is completed (not a suspension and therefore, not reportable as a suspension). MEC will lay out consequences of next steps if physician is not agreeable.

14.3.6.8 Educational Leave of Absence.

14.3.6.9 *Conflict of Interest*: A member of the medical staff requested to perform peer review has a conflict of interest if he or she is not able to render an unbiased opinion. An automatic conflict of interest results if the physician is the provider under review. Relative 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 physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an automatic or substantial relative conflict is determine to exist, the individual may not participate or be present during peer review body discussions or decision other than to provide specific information requested as described in the Peer Review Process.

14.3.6.10 *Physician Occurrence Report:* A physician occurrence report is a report documented within the web-based event reporting system. All physician occurrence reports are immediately evaluated under the auspices of this policy and are protected by Arizona State Law.

*Licensed Independent Practitioner's (LIP's) are subject to the same peer review policy concurrently with their directly supervising physician.

14.4 **Guidelines**

14.4.1 All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and nondiscoverability.

14.4.2 The involved practitioner receives provider-specific feedback on a routine basis.

14.4.3 The medical staff uses the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

14.4.4 The hospital keeps provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to

14.4.4.1 Performance data for all dimensions of performance measured for that individual physician

14.4.4.2 The individual physician's role in sentinel events, significant events, or near misses

14.4.4.3 Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action in the form of a PIP.

14.4.5 Only the final determinations of the peer review activities and any subsequent actions are considered part of an individual provider's quality assessment. Any written or electronic documents related to the review process, other than the final committee decisions, are considered working notes of the committee and are to be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, questions and notes of the physician reviewers, requests for information from the involved physicians, and any written responses to the committee.

14.4.6 Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as medical staff leaders or hospital employees. However, access to the information is only to the extent necessary to carry out their assigned responsibilities. The Quality Management (QM) Department ensures that only authorized individuals have access to individual provider quality files, and that the files are reviewed under the supervision of the Director of Quality Management or designee. Only the following individuals have access to provider-specific peer review information, and only for purposes of quality improvement:

14.4.6.1 The specific provider

14.4.6.2 Medical Staff Officers

14.4.6.3 The Medical Staff Peer Review Body

14.4.6.4 Medical staff department chairs (for members of their departments only)

14.4.6.5 Members of the medical executive, credentials, and quality committees

14.4.6.6 The director of Quality Management and staff supporting the peer review process

14.4.6.7 Medical staff services professionals, to the extent that access to this information is necessary for the recredentialing process or formal corrective action

14.4.6.8 Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., federal or state regulatory bodies)

14.4.6.9 Individuals with a legitimate purpose for access as determined by the hospital board of directors

14.4.6.10 The hospital Chief Executive Officer (CEO) or designee, when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.

14.4.7 No copies of peer review documents are created and distributed unless authorized by medical staff policy or bylaws, the MEC, the board, or by the Chief of Staff for purposes of deliberations regarding corrective action on specific cases.

14.5 **Circumstances Requiring Peer Review**

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedure for conducting peer review is described below. Additional evaluations are conducted when there is a sentinel event, a near miss, or an unusual individual case.

14.6 **Participants in the Peer Review Process**

Participants in the review process are selected by the Peer Review Body. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff participate if such participation is included in their job responsibilities, such as the CEO, Chief Nursing Officer (CNO), Risk Manager, and Director of Quality Management. The peer review body considers and records the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in the time frame outlined in the Procedure for Peer Review.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MEC replaces, appoints, or determines who participates in the process so that bias does not interfere in the decision-making process.

14.7 **Threshold for Intensive Review**

14.7.1 If the results of individual case reviews for a physician exceed the thresholds established by the Medical Staff described below, the physician involved is contacted by certified mail that he/she is to be reviewed for exceeding thresholds (as written below) and has 6 days to provide any documentation to be attached to the review process documents. If the supporting documentation addresses the concerns raised, the physician is notified by mail that the concerns were addressed.

14.7.2 If the review is to proceed, the involved physician will be invited, with a 14 day notice, to attend the Peer Review Body to give input into the discussion of cases where the threshold is met or exceeded. The Peer Review Body will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.

14.7.3 Thresholds:

- 14.7.3.1 Any single egregious case
- 14.7.3.2 Within any 12-month period of time, any one of the following criteria:
  - 14.7.3.2.1 Two cases with physician clinical judgment or decision-making; diagnoses, or with issues identified with technical skills
  - 14.7.3.2.2 Four cases with identified issues related to communication, documentation, follow through and other related issues

14.8 **Peer Review for Specific Circumstances**

In the event that a decision is made by the MEC or Governing Board to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as ordered by the MEC.

14.9 **Peer Review Time Frames**

Peer review is conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the QM Department and for complex cases to be completed within 120 days. Exceptions are based on Case complexity or reviewer availability.

14.10 **Oversight and Reporting**

Direct oversight of the peer review process is delegated by the MEC to the Quality Initiative subcommittee: the Peer Review Body. The responsibilities of the Peer Review Body related to peer review are described in the Quality Initiative Charter. A Report is generated for MEC and the Governing Board at least quarterly.

14.11 **PROCEDURE**

14.11.1.1 Scope Of Peer Review

14.11.1.2 All SHRMC patient cases are candidates for Peer Review. Patient cases are routinely selected for Peer Review through the systematic assessment of data and the use of Peer Review Indicators. Reviews are conducted concurrently or retrospectively on any physician providing care to that patient and are not limited to the attending physician on the case.

14.11.1.3 Physicians are required to actively participate in Medical Peer Review. (ByLaws 3.2.3.2)

14.11.2 Peer Review Indicators

14.11.2.1 Routine Peer Review Indicators. The Medical Staff Departments, from time to time, establish Routine Peer Review Indicators to be used to select cases for review. These Routine Peer Review Indicators are established to ensure that cases are selected in sufficient numbers and sufficient detail to effectively assess and evaluate all aspects of the quality of patient care provided to the patients of SHRMC. Routine Peer Review Indicators are automatically sent for review and do not proceed through the Peer Review Body. (See Attachment A)

14.11.2.2 Physician Occurrence Report and Patient Grievance. The Peer Review Body screens and approves all validated occurrence reports and patient grievances for peer review. All occurrence reports and patient grievances that are not validated have the physicians identification removed from the report and the report is not used for trending purposed for that physician.

14.11.2.3 Extraordinary Peer Review Indicators. The occurrence of any of the following, in connection with a patient case, constitutes an Extraordinary Peer Review Indicator.

14.11.2.3.1 A Sentinel Event (A sentinel event is an unexpected

occurrence involving death or serious physical or psychological injury, or the risk thereof.)

14.11.2.3.2 A Near Miss (The risk of a sentinel event including any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.)

14.11.2.3.3 The request for a review from the Chief of Staff.

14.11.2.3.4 The request of Risk Management, the Corporate Compliance Officer, the Department Chairman, and/or the Director of Quality Management. (Clinical issues that are brought to the attention of an Administrator are discussed with the Peer Review Body prior to being sent for Peer Review).

The Medical Executive Committee, from time to time, establishes additional Extraordinary Peer Review Indicators to be used to select cases for review.

14.12 Process for Occurrence Reports and Patient Grievances:

14.12.1 Employee completes occurrence report or complaint in web-based program and submits report electronically to Department Director where event occurred and Quality Management Department.

14.12.2 The Department Director starts investigation and completes his/her follow up actions in web based program. The Director may communicate with the physician as needed.

14.12.3 Quality Management (QM) staff investigates and validates the occurrence report or complaint. If validated, the physicians name is entered into the database for future data mining. Medical Staff Services is notified.

14.12.4 If the event is not validated, the physician's name is removed from the tracking mechanism of the event and the event is not included in trending for that physician.

14.12.5 QM Service Line staff compiles a list of validated physician occurrence reports and complaints in web-based program with the visit number, the event/ticket number, and sends the information to Medical Staff Services for credentialing.

14.12.6 QM staff notifies the appropriate Department Chairman and each physician in a certified letter of the occurrence reports and complaints received during the month and provides information on how the physicians can view occurrence reports and complaints in the Quality Management office.

14.12.7 Physicians request an appointment to view occurrence reports and complaints to provide their feedback at their convenience. QM staff assists physicians by retrieving the event and ticket numbers for their review. QM staff enters the physician review into the feedback section of the event with the date, time, and any comments the physician would like entered.

14.12.8 QM reviews the validated occurrence report/complaint with Risk Manager, Medical Staff Services and/or Peer Review Body for decision regarding peer review.

14.12.9 If no further review is needed of occurrence report or complaint, the report or complaint is trended for credentialing cycle.

14.12.10 If Peer Review is needed, the occurrence report is referred to QM

staff for arrangement for Peer Review.

14.12.11 The occurrence report or complaint is attached to the peer review documents along with any comments from the physician involved and other supporting documentation.

14.12.12 The peer review and all paperwork are returned to the QM department who closes case or arranges for review with Department.

14.13 Selection and Screening of Cases for Review

14.13.1 Screening by Quality Management. Summit Healthcare patient cases are screened by QM for the presence of Peer Review Indicators and for Corporate Compliance. All Summit Healthcare patient cases that present with a Peer Review Indicator, Extraordinary Peer Review Indicator, or a Corporate Compliance Indicator are segregated by Quality Management for Registered Nurse (RN) Pre-Review.

14.13.2 RN Pre-Review of Cases Presenting with Peer Review Indicators. All Summit Healthcare patient cases that present with a Peer Review Indicator are pre-reviewed by a qualified RN in the Quality Management Department.

14.13.2.1 The Quality Management RN who Pre-Reviews cases which present a Peer Review Indicator documents the cases reviewed and the indicator or reason for each review.

14.13.2.2 Each case pre-reviewed by the Quality Management RN are classified and referred for further action as follows:

14.13.2.2.1 No further action necessary

14.13.2.2.2 Physicians who have a case being reviewed are contacted by certified mail that the case is to be reviewed and he/she has 6 days to provide any documentation to be attached to the case being reviewed

14.13.2.2.3 After the 6 days allotted, cases are referred to the Peer Review Body for review and determination of the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed. (Department Chairmen are notified of all cases going for peer review.)

14.13.2.2.4 Eligible physicians for the peer review are assigned on a rotational basis.

14.13.2.2.4.1 The physician to review the case is notified in writing that a case has been assigned for their peer review.

14.13.2.2.4.2 The physician has 14 days to complete the peer review.

14.13.2.2.4.3 The physician returns his/her findings of the case on the provided Peer Quality Review Form to the Quality Management Office.

14.13.2.2.4.4 If the reviewing physician feels that there is a technical component requiring further review of which he/she is not qualified to perform, the case is returned to the Peer Review Body with any comments and the review of the general

medical care.

14.13.2.2.5 The physician whose care is being reviewed is notified after the peer review is completed that a case of his/hers went for peer review, the reason it was reviewed, and the result of the peer review. If findings indicate an issue, the peer review is sent to the appropriate Department meeting.

14.13.3 Expedited Review of Cases with Extraordinary Peer Review Indicators. Any case involving Extraordinary Peer Review Indicators, at the discretion of the Chief of Staff, receives review at the next scheduled Department meeting. The physician(s) whose care is the subject of any such case is provided prompt notice that such case has been referred to the Department meeting for expedited review and is asked to be present at the Department meeting. Those physicians are provided individual peer review evaluations.

14.14 Peer Review Results

14.14.1 The Peer Quality Review Form (Attachment A) is completed for each peer review done.

14.14.2 All patient cases that are sent to a physician reviewer for Peer Review are classified according to the following criteria:

14.14.2.1 No further follow-up needed.

14.14.2.2 Department review of identified issues and actions needed.

14.14.2.3 Cases referred to Department Peer Review combines the peer review process with a comprehensive review of the system issues surrounding the care in question.

14.14.2.4 Cases referred to the Department Peer Review with nursing issues requests that the CNO and appropriate Nursing Director be present for the review.

14.14.3 Reviewing physicians must submit, in writing, concerns regarding the course of patient management when completing a peer review as well as when referring a case to the department meeting for review.

14.14.4 At the reviewing physician's discretion, the patient case may be referred to the Department meeting for Educational Purposes.

14.15 Department Peer Review

14.15.1 The Quality Management Department provides written notification to the physician being reviewed as well as the Physician Reviewer at least 14 days prior to the scheduled department meeting that the case is being reviewed and their attendance is requested.

14.15.2 The Department Chairman makes every effort to have both the reviewer and the physician whose case is to be reviewed by the Department, attend the meeting at which it will be discussed. Departmental review may be postponed monthly if either party is unable to attend and requests a postponement. The Department Chairman arranges for cases to go to Department and is responsible for notifying both the physicians involved. If either physician is unable to attend the Department meeting within three months, the Department Chairman may decide to have case reviewed in the absence of the reviewer and the physician involved. The involved physician submits any reviewing concerns in writing prior to the scheduled Department

review.

14.15.3 The Department Chairman and membership may request actions in the form of an educational letter or a collegial intervention related to the issues identified. The Department Chairman and membership may also request further review by the Peer Review Body or MEC.

14.15.4 Cases are not reviewed more than once for the same concern or involved physician by each Department. Cases, however, are reviewed more than once if different medical disciplines and/or physicians are involved.

14.15.5 The actions of the Department are reported to the Peer Review Body and the case is closed or a Performance Improvement Plan (PIP) is created if warranted. Recommendations of the PIP are forwarded to MEC for approval and implementation. All actions taken are reported back to the Peer Review Body for closure.

14.15.6 If the physician being reviewed disagrees with the review outcome, he/she has 60 days to submit a written request for further review to the MEC. If the MEC deems it appropriate, the case is referred to an outside reviewer for additional evaluation. Results of the MEC review is communicated to the physician being reviewed within 30 days.

14.16 Recording and Use of Peer Review Results

14.16.1 Upon completion of the Peer Review, the patient case medical record and the completed Peer Quality Review Form are returned to the QM Department for completion.

14.16.2 Peer Review final results are aggregated with identified issues and submitted to the Credentialing Committee with documentation of completed actions.

14.16.3 Peer Review results are kept a minimum of 7 years or in the case of a pediatric patient, the Peer Review is kept until the patient is 21 years old plus 3 years. (Per advice of legal counsel)

14.17 EXTERNAL PEER REVIEW

External Peer Reviews are requested by the Chief of Staff and/or Peer Review Body for situations such as: absence of peer reviewer with same technical specialty, conflict of interest, personal conflict, and/or the physician reviewers do not feel qualified to evaluate the situation. In addition, external peer review may be utilized at the discretion of the Chief of Staff and/or the Peer Review Body for issues where a threshold for intensive review has been met (Threshold for Intensive Review).

14.17.1 The Quality Management Department facilitates outside Peer Review. The Quality Management Department attempts to meet any specific directions provided by the Chief of Staff and/or the Department Chairman.

14.17.1.1 The Quality Management Department collects a Curriculum Vitae attesting that the physician doing the External Peer Review is Board certified, currently licensed, and in good standing with his medical licensing body. The external reviewer or reviewers are approved by the Peer Review Body or Department Chairman prior to the review.

14.17.1.2 The external physician reviewer and the hospital agree on the cost of the External Peer Review.

14.17.1.3 The external physician reviewer and the Quality Management Department agree on the expected time frame of the external

peer review.

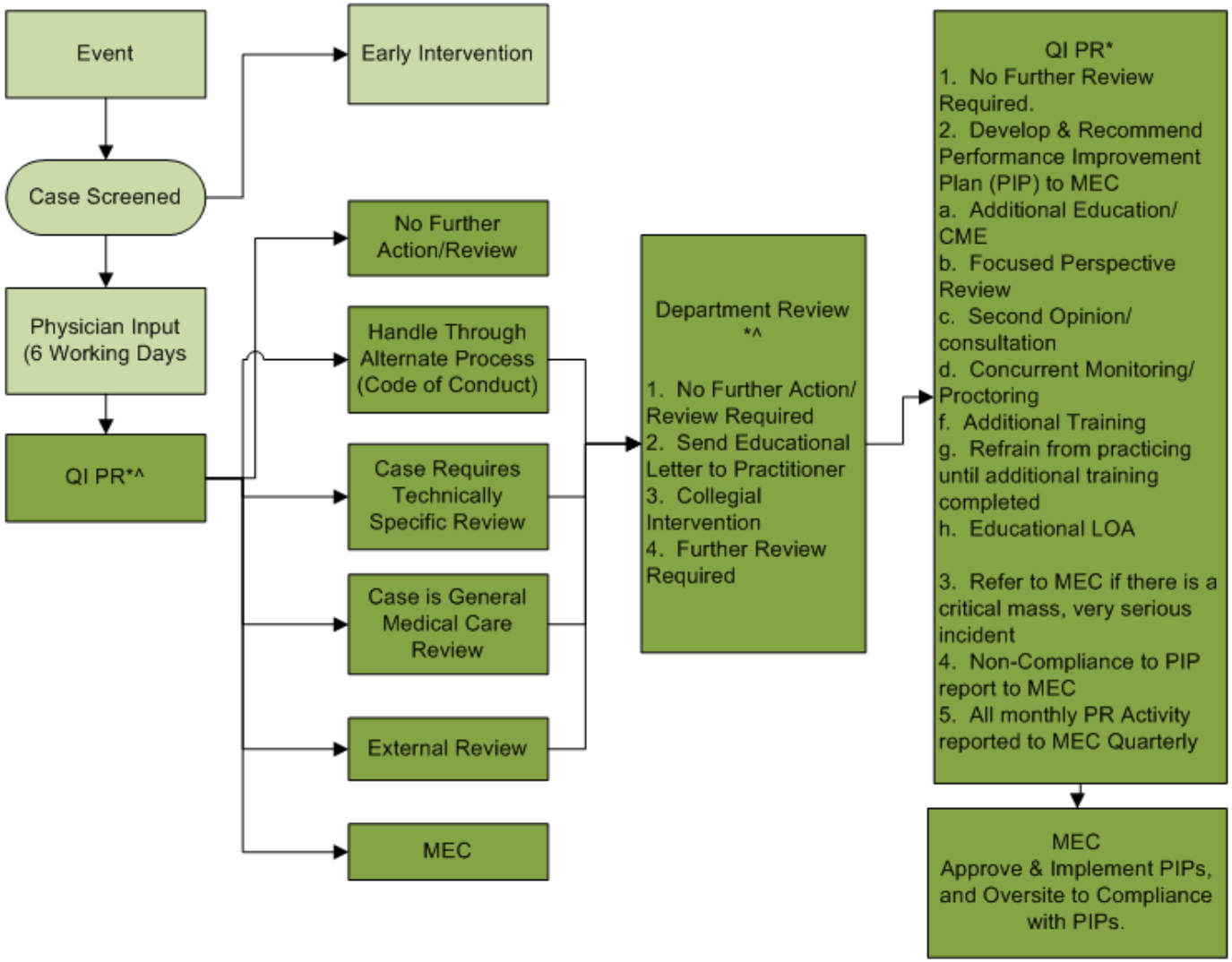
14.17.1.4 All communications with the external physician reviewer is with the Quality Management Department and the Peer Review Body only. Any communication with the external physician reviewer by anyone else disqualifies the external physician reviewer from participating in the peer review case.

14.17.1.5 External peer review arrangements with rural hospitals of a similar size are utilized at the discretion of the Peer Review Body.

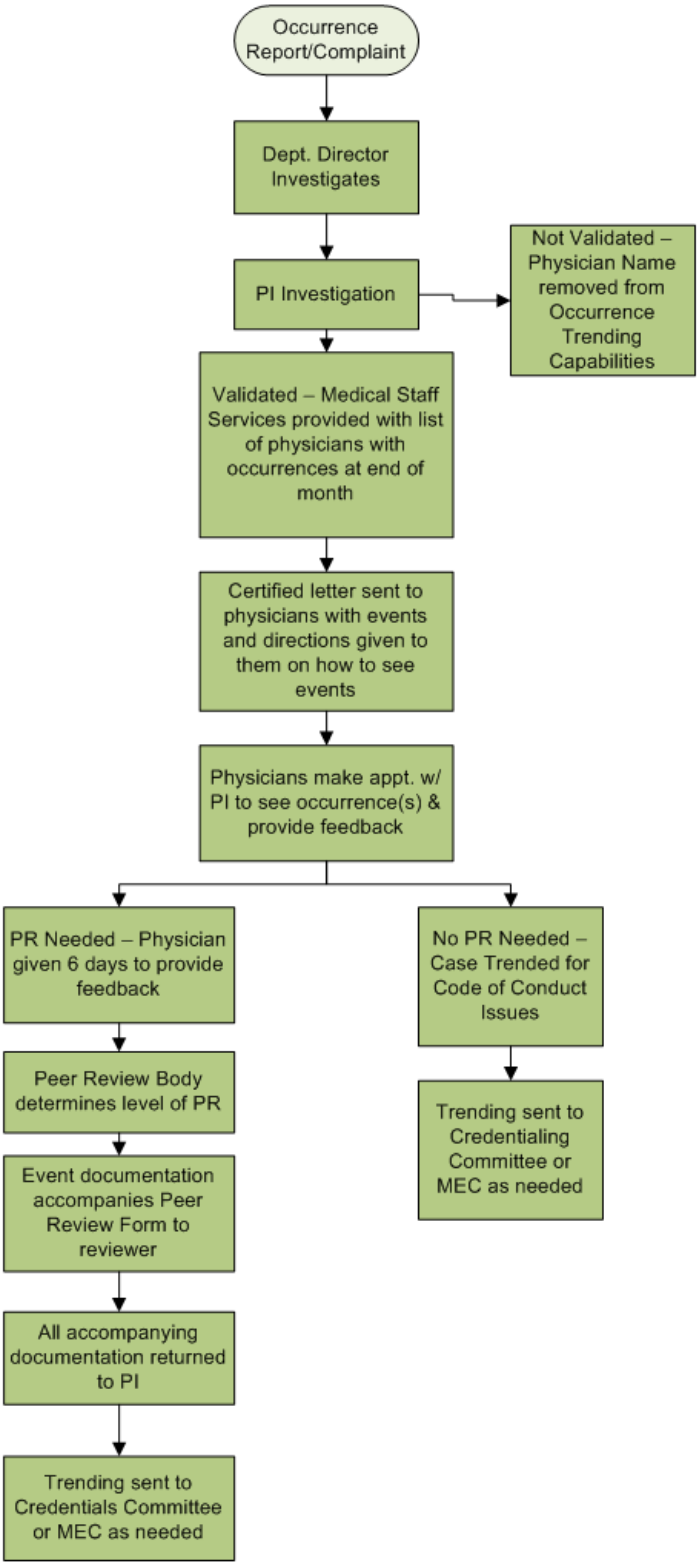
14.17.1.6 The external physician reviewer is requested to give an objective, expert opinion on the quality and appropriateness of the care provided by the physician being reviewed. The report by the external physician reviewer is confined to an evaluation of the care provided, does not include editorial comments about the internal review process, speculations about why certain issues were raised, or recommendations regarding the physician's clinical privileges.

14.17.2 All external peer review reports receive a final review at the appropriate department and actions taken are as above for internal peer review. If an external review is requested by the Chief of Staff or the Peer Review Body, the results of the external review will go to the committee that requested it. The involved physician will be invited to attend that meeting as per the guidelines above (i.e. 2 week notice).

Summit Healthcare Peer Review Process



Summit Healthcare Occurrences Report Flow Chart



ADOPTION

This Medical Staff Rules and Regulations is adopted and made effective upon approval of the Governing Board, superseding and replacing any and all other Medical Staff Rules and Regulations, rules, regulations, policies, manuals or Medical Center policies pertaining the subject matter thereof.

Adopted by the Medical Staff on: ***July 19, 2011***
Dated

Approved by the Governing Board on: ***July 21, 2011***
Dated