

MEDICAL STAFF RULES AND REGULATIONS

Table of Contents

SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS4

1.1 GENERAL ADMITTING POLICY4

1.2 ADMITTING PRIVILEGE4

1.3 DENTIST/PODIATRIST ADMISSIONS.....4

1.4 GENERAL RESPONSIBILITIES OF ADMITTING PRACTITIONER.4

1.5 CONTACT PREFERENCE, ON-CALL/ON-DUTY REQUIREMENTS.....4

1.6 PATIENT ADMISSIONS AND OBSERVATION SERVICES6

1.7 CONTINUED STAY7

1.8 EMERGENCY ADMISSION WITHOUT PCP.....7

1.9 PRACTITIONER RESPONSIBILITY FOR STAFF/PATIENT SAFETY7

1.10 PRECAUTIONS IN THE SUICIDAL PATIENT7

1.11 TRIAGE7

1.12 TRANSFERS.....8

1.13 TRANSPORTS – SENDING AND RECEIVING8

1.14 DISCHARGES.....9

1.15 DEATH.....9

2.2 HISTORY AND PHYSICAL.....11

2.3 CLINICAL ENTRIES.....12

2.4 OPERATIVE REPORTS.....13

2.5 PROCEDURE NOTES14

2.6 CONSULTATION REPORTS14

2.8 AUTHENTICATION (REV. 07/11; 04/15/10).....14

2.9 ABBREVIATIONS AND SYMBOLS15

2.10 DISCHARGE SUMMARY.....15

2.11 CONFIDENTIALITY OF MEDICAL RECORDS16

2.12 PHYSICIAN ORDERS.....16

2.13 E.D. MEDICAL RECORDS19

2.14 INTRAOPERATIVE & POST ANESTHESIA/SEDATION RECORD20

2.15 SPECIAL STUDIES.....20

2.16 AMENDING MEDICAL RECORD ENTRIES.....20

2.17 TIMELY COMPLETION OF MEDICAL RECORDS DOCUMENTS22

SECTION 3. GENERAL CONDUCT OF CARE.....27

3.1 CONSENTS27

3.2 INVESTIGATIONAL DRUGS27

3.3 CONSULTATIONS27

3.4 REPORTABLE DEATHS AND AUTOPSIES28

3.5 TELEMEDICINE ENCOUNTERS FOR NON-PROCEDURAL CORE PRIVILEGES.....29

SECTION 4. RULES REGARDING SURGICAL CARE30

4.1 SCHEDULING.....30

4.2 MAJOR SURGERY.....31

4.3 SURGERY REQUIRING AN ASSISTANT31

4.4 SURGICAL CONSENTS31

4.5 SURGERY START TIME.....31

4.6 ROUTINE PRE-OPERATIVE CHECKS31

4.7 PRE-OPERATIVE ORDERS32

4.8 PRE-OPERATIVE LABORATORY WORK.....32

4.9 PRE-OPERATIVE DIAGNOSIS.....32

4.10 VERIFICATION OF SURGICAL PRIVILEGES32

4.11 TISSUE REQUIRING PATHOLOGICAL EXAMINATION.....32

4.12 DENTAL AND PODIATRIC SURGERY32

4.13 SURGICAL EQUIPMENT32

4.14 SURGICAL DEATHS32

4.15 RECOVERY ROOM.....32

SECTION 5. RULES REGARDING ANESTHESIA CARE.....34

5.1 ANESTHESIA COVERAGE.....34

5.2 PRE-ANESTHESIA EVALUATION.....34

5.3 PRE-INDUCTION*34

5.4 ANESTHESIA AGENTS PERMITTED IN HOSPITAL34

5.5 ANESTHESIA AGENTS PERMITTED IN DELIVERY ROOM34

5.6 GENERAL ANESTHESIA IN DELIVERY.....34

5.7 PRE-OPERATIVE GUIDELINES FOR ANESTHESIA SERVICES34

5.8 CONSCIOUS SEDATION.....34

SECTION 6. RULES REGARDING OBSTETRIC/NEWBORN CARE36

6.1 STANDARD OF CARE36

6.2 MATERNAL/NEONATAL TRANSPORT36

6.3 LABOR RULES.....37

6.4 DELIVERY RULES38

6.5 RECOVERY.....38

6.6 NEWBORN RULES39

SECTION 7. RULES REGARDING EMERGENCY SERVICES40

7.1 TYPES OF SERVICES40

7.2 PHYSICIAN STAFFING.....40

7.3 OBSERVATION41

7.4 DIRECT ADMITS.....41

7.5 TRANSFERS FROM THE EMERGENCY DEPARTMENT41

SECTION 8. RULES REGARDING SPECIAL CARE UNITS42

8.1 SERVICES42

8.2 ADMISSION & TRANSFER ELIGIBILITY42

8.3 ELIGIBILITY42

8.4 PATIENT PRIORITY42

8.5 PATIENTS WHO DO NOT MEET ROUTINE ADMISSION CRITERIA.....43

8.6 TRANSFERS.....43

8.7 DISCHARGES.....44

8.8 STANDING ORDERS AND PROTOCOLS44

8.9 MEDICAL STANDARDS.....44

SECTION 9. RULES REGARDING OUTPATIENT CLINICS.....45

9.1 NARCOTICS IN CLINICS.....45

9.2 EMERGENCY CARE SERVICES IN OFF-CAMPUS LOCATIONS.....45

SECTION 10. DISASTER PLAN RULES46

10.1 DISASTER PLAN49

10.2 MEDICAL STAFF DISASTER DRILL ASSIGNMENTS.....49

10.3 MEDICAL AUTHORITY49

SECTION 11. DISRUPTIVE AND INAPPROPRIATE BEHAVIORS50

SECTION 12. PROFESSIONAL STAFF WELLNESS POLICY.....57

12.1 PURPOSE:.....57

12.2 DEFINITIONS:57

12.3 PROCESS:.....57

12.4 PHYSICIAN WELLNESS POLICY FLOWCHART59

SECTION 13. MEDICAL STAFF PROFESSIONAL CODE OF CONDUCT.....60

13.1 INTERPERSONAL RELATIONSHIPS60

13.2 PATIENT-CENTERED CARE60

13.3	SAFETY	60
13.4	PROFESSIONAL PRACTICE	60
13.5	DISRUPTIVE AND INAPPROPRIATE BEHAVIORS	61
SECTION 14. PEER REVIEW POLICY & PROCEDURE		62
14.1	POLICY STATEMENT	62
14.2	CONFIDENTIALITY, IMMUNITY, AND COMPLIANCE WITH STATE LAW:	62
14.3	DEFINITIONS	62
14.4	GUIDELINES	65
14.5	CIRCUMSTANCES REQUIRING PEER REVIEW	67
14.6	PARTICIPANTS IN THE PEER REVIEW PROCESS	67
SECTION 15. MEDICAL STAFF CONFLICT OF INTEREST GUIDELINES		72
15.1	GENERAL PRINCIPLES	72
15.2	IMMEDIATE FAMILY MEMBERS	72
15.3	EMPLOYMENT OR CONTRACTUAL RELATIONSHIP WITH THE MEDICAL CENTER	72
15.4	ACTUAL OR POTENTIAL CONFLICT SITUATIONS:	72
15.5	GUIDELINES FOR PARTICIPATION IN CREDENTIALING AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES	73
15.6	GUIDELINES FOR PARTICIPATION IN DEVELOPMENT OF PRIVILEGING CRITERIA:	73
15.7	RULES FOR RECUSAL	74
15.8	OTHER CONSIDERATIONS	74
ADOPTION		77

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

Patients may be admitted to the hospital, to include swing beds, by members of the Active Medical Staff, approved Telemedicine 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.

1.5 Contact Preference, On-Call/On-Duty Requirements

1.5.1. All credentialed providers will be provided a document to reflect the respective provider's contact preference and the order in which they are to be used.

- 1.5.2 Each provider will be required to provide at a minimum a primary and backup phone or paging number.
- 1.5.3 Each provider will be required to review, update if necessary, and return the Provider Contact Preference Form to Summit Healthcare's Medical Staff Services Department with his/her initial and reappointment application packet.
- 1.5.4 The Provider Contact Preference List will be updated and placed on the hospital intranet.
- 1.5.5 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.
- 1.5.6 The on-call/on-duty provider will be required to respond to calls, texts, pages, or other communication methods as may be established in the future with in thirty (30) minutes in accordance with the Hospital's On Call Policy. Reasonable multiple attempts will be made by Hospital staff to contact the on-call/on-duty provider within the 30 minute time standard or more frequently as the situation dictates for emergencies.
 - 1.5.6.1 Non-emergent messages may be sent via a HIPAA compliant electronic message (i.e. text message) and are expected to be addressed by the provider within a reasonable timeframe (not to exceed 5 hours).
- 1.5.7 The on-call/on-duty 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.
- 1.5.8 A central log will be established in applicable hospital departments that documents time of call, number called, and time of response or no response.
- 1.5.9 If a clinical situation necessitates immediate intervention prior to the response to a call or other communication method during the thirty (30) minute time standard, either the Rapid Response Team or Emergency Physician will be requested to assess and manage the patient.
- 1.5.10 Failure of the on-call/on-duty provider to respond to an emergent call or other communication method within thirty (30) minutes will result in the completion of an occurrence / incident report.
 - 1.5.10.1 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.

- 1.5.10.2 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.
- 1.5.10.3 All occurrence / incident reports involving credentialed providers will be forwarded to the attention of the Performance Improvement Department for validation purposes.
- 1.5.10.4 All validated reports will be reviewed by the Professional Review Committee for trending and action.
- 1.5.11 Policy non-compliance will be defined as three (3) or greater occurrences with in a rolling two (2) year period.
- 1.5.12 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" policy.
- 1.5.13 Prior to any notice of non-compliance being forwarded to the attention of the respective physician, or activation of the Disruptive Physician policy, hospital administration will confer with the Chief of Staff.

1.6 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.

- 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)

1.7 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.

1.8 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)

1.9 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.

1.10 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 be evaluated in accordance with Hospital policy within 24 hours of presentation and the documented in the medical record. Mental health assessment from another accredited facility may be utilized if the patient is presenting for medical clearance.

Rev. 04/2013

1.11 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.

1.12 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)

1.13 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

1.14 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.

1.15 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 RECORDS2.1 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.
- c) A medical record is established and maintained for each patient who has been treated or evaluated at Summit Healthcare. The medical record, including electronic data and medical imaging are the property of Summit Healthcare Association.
- d) Responsibility: The attending physician is responsible for each patient's medical record. The medical record must identify who has primary responsibility for the care of the patient. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered into the patient's medical record. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician.

- e) Information from Outside Sources: Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to Summit Healthcare and that are required for or directly related to the admission are made a part of the patient's hospital record.

(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
 - For gero-psychiatry patients: social history to include social, educational, vocational, interpersonal, and family relationships
 - For gero-psychiatry patients: Neurological screening and exam that includes: neurological problems presented, and recorded by major category (cranial nerves, sensory/motor coordination, deep tendon reflexes, etc.)

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.
 - Is in the medical record prior to surgery or a non-surgical procedure requiring anesthesia.
 - 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)

- d) 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.
- e) 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.
- f) 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.
- g) 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 Clinical Entries

- a) All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.
- b) Physician Assistants and nurse practitioners may enter orders including admission orders. Orders do not require counter-authentication by the physician.
- c) Progress notes should be documented or dictate with a frequency that reflects appropriate attending involvement but at least every day. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before. Progress notes should describe not only the patient's condition, but also include response to therapy.

- i. Gero-Psychiatry progress notes are keyed to problems (i.e., problem oriented), demonstrate medical necessity, severity of symptoms, reflect interventions and outcomes, changes in drug therapy, and dosages and address patient status in attaining treatment goals stated on the treatment plan. Progress notes are charted utilizing a behavioral format such as BIRP, DAR, PIP, SOAP, or others as appropriate.
 - A. Frequency of the attending physician's progress note is minimally five times per week. The physician note descriptively documents severity of symptoms/behaviors that support medical necessity for continued stay for level of care.
 - B. Frequency of clinician's individual therapy progress notes, family meeting, or discharge planning documentation is documented on the day of the intervention. Summary notes may be written on a weekly basis at a minimum.
- d) Admitting Note – The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

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 but within 24-hours post 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 Ambulatory Patient Records

Records for patients who receive ambulatory care on an ongoing basis should contain a summary list of known, significant diagnoses and known medications. The outpatient portion of the chart should also be available when a patient returns to the medical center for treatment.

Office encounter(s) closed with supporting documentation that reflects the patient encounter in the practice EMR within five (5) business days of the patient encounter. Coding and billing inquiries are to be completed within five (5) business days of posting.

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

- a) All clinical entries and attestations in the patient's 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.
- c) Counter-authentication (endorsement)
 - i. Physician Assistants/Nurse Practitioners (admitted patients) – History & Physical Reports, Operative/Procedural Notes, Consultations and Discharge Summaries must be counter-authenticated by the

supervising/sponsoring physician. Each clinical event must be counter-authenticated within 48 hours.

- ii. Physician Assistants/Nurse Practitioners (outpatient/Hospital Department clinics) – Counter-authentication is not required for orders written by a Physician Assistant/Nurse Practitioner. A monthly audit of not less than 10% of the Physician Assistant’s charts shall be reviewed and signed off on by the Supervising/Sponsoring Physician.
- iii. Residents/Fellows – Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor countersignatures by Residents/Fellows. Appropriate action will be taken by the specific training program.
- iv. 1st & 2nd Year Medical Students – Access to view the patient chart only. May not document in the medical record.
- v. 3rd & 4th Year Medical Students – Any and all documentation must be endorsed (countersigned, counter-authenticated) timely by the physician.

2.9 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)

2.10 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)

Discharge summaries for gero-psychiatry patients shall include: brief summary of present illness; psychiatric history; physical examination, laboratory data; consultations; summary of hospital course; Suicide Risk Assessment; discharge medications; condition upon discharge; final diagnosis; and disposition to include: residential disposition, follow-up treatment plan, and medications.

- 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)
- d) Discharge summaries should be completed at the time of patient discharge, but within 48 hours (including discharges from the Emergency Room) after discharge.

2.11 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 of 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.
- g) Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Summit Healthcare safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering.
- h) Passwords – All practitioners must maintain the confidentiality of passwords and may not disclose such passwords to anyone.

2.12 Physician Orders

- a) All orders for treatment are in writing, justify medical necessity, are signed, dated, and timed by the attending practitioner when required. 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:

- i. Registered Nurses (RN) or Licensed Practical Nurses (LPN)
 - ii. Registered Pharmacists
 - iii. Respiratory Therapists (for R.T.)
 - iv. Physical Therapists (for P.T.)
 - v. Registered Dietitian (for diet orders including tube feedings and TPN) or designee (for diet orders and nutrition supplements only).
 - vi. A.R.R.T. (For diagnostic imaging)
 - vii. C.N.M.T. (For nuclear medicine)
 - viii. M.T. (For lab procedures) (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)
- d) Verbal Orders - Verbal and telephone orders can be taken only from a physician, a Physician Assistant (PA) under a physician's direction, or a Registered Nurse, Nurse Practitioner or Licensed Practical Nurse under a physician's direction.
- i.. 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

- e) 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.
- f) 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.
- g) 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.
- h) When a patient goes to surgery or cardiac cath lab, all physician orders related to nursing and ancillary procedures (with exception of code status which is discontinued) are placed on hold for the duration of the perioperative period. Medication orders are kept active but are not acted upon. If the patient returns to the *same* level of care following surgery, orders (including medical orders) are continued unless the patient had general or neuraxial anesthesia. In that case, medication reconciliation must occur when post-operative orders are written. If the patient is transferred to a higher or lower level of care following surgery, medication reconciliation must also occur when post-operative orders are written. When the patient has sedation for a procedure outside the surgery department, all orders are continued and medication reconciliation is not required

When medication reconciliation contains complex medication orders, the surgeon may communicate with the attending for assistance.

Medication Reconciliation must occur:

- If patient has general or neuraxial anesthesia
- If patient is changing level of care following surgery (i.e. previously Med Surg patient but is returning to ICU)
- If patient is changing level of care within the hospital

- If a patient has general anesthesia for a radiological procedure. Medication reconciliation will be completed by the attending provider.

When in doubt, do a medication reconciliation.

- i) The Medical Staff shall adhere to the Medical Center's policy for use of restraints for voluntary/involuntary immobilization of patients. Added 09/2009; Rev. 10/2014
- j) 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.
- k) Services in the Outpatient Setting – Outpatient Services in the hospital may be ordered (and patients may be referred for hospital outpatient services) in accordance with CMS Guidelines. The Hospital verifies that the referring practitioner who is responsible for the patient's care is appropriately licensed and acting within his/her scope of practice in accordance with Hospital policy regarding Sanction screening. Rev. 10/2014
- l) Drug/Medication Orders
 - i. 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.
 - ii. All controlled substances, II through V, are required to be re-ordered every three days (72 hours).
 - iii. All antibiotics are required to be re-ordered every seven (7) days.
 - iv. 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.

2.13 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:
 - i. Adequate patient identification;
 - ii. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
 - iii. Pertinent history of the injury or illness including place of occurrence and physical findings including the patient's vital signs and details relative to first aid or emergency care given prior to arrival at the hospital;
 - iv. Clinical observations, including results of treatment

- v. Diagnostic impression
 - vi. Treatment given
 - vii. Condition of the patient on discharge or transfer; this shall be stated in terms permitting specific measurable comparison, not "improved", "good", etc.
 - viii. 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.
 - ix. Whether the patient left against medical advice
- b) Each patient's Emergency Department record shall be authenticated by the practitioner in attendance who is responsible for its clinical accuracy in accordance with these documents.

2.14 Intraoperative & Post Anesthesia/Sedation Record

- a) An intraoperative anesthesia/sedation record will be maintained for each patient and include drugs/agents used, pertinent events during indications, maintenance of emergence from anesthesia/sedation, all other drugs, intravenous fluids and blood components given.
- b) Documentation in the post anesthesia/sedation care unit includes the patient's level of consciousness upon entering and leaving the area, vital signs, and status of infusions, drains, tubes, catheters and surgical dressing (when used), unusual events or complications and management.
- c) A post anesthesia/sedation evaluation for proper recovery of anesthesia/sedation must be completed and documented by an individual qualified to administer anesthesia/sedation within 48 hours after the procedure or prior to the patient being discharged or transferred from the post anesthesia/sedation care area regardless of type or location where anesthesia/sedation is performed.

2.15 Special Studies: EEGs, EKGs, treadmill stress tests, echocardiograms, tissue, medical imaging, fetal monitor strips, and other special procedure reports will be interpreted and documented within 48 hours (24 hours for medical imaging) of notice/communication to the physician or agent to inform the provider of the test completion. Rev. 05/2016

2.16 Amending Medical Record Entries

- a) Electronic Documents (Structured, Text and Images) – Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the Electronic Medical Record (EMR). The EMR will track all changes made to entries.

Once an entry has been authenticated and an error is found in the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will date and time stamp the entry.

If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in

error must be documented as such by the author, and the author will re-enter the information on the correct patient.

- b. Paper-Based Documents – Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing, dating, and timing the error.

Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIM Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.

Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

2.17 Timely Completion of Medical Records Documents – All medical records shall be completed within the timeframes defined below:

Documentation Requirement	Timeframe	Exclusions	Reference
Acute Care Criteria	Daily		R&R 1.5 & 1.6
Emergency Room Report	Documented within 24 hours of discharge/disposition from the ED		
Progress Note	Daily		CMS 482.24 (c)(1) [Authentication]
Progress Notes – Gero-Psychiatry	Minimally five times per week		CMS 482.61(d)
History & Physical (less than 30 days old)	Documented within 24 hours of admission to inpatient or observation status, but prior to surgery. Update to the H&P must be done no more than 24-hours after admission but prior to surgery or procedure requiring anesthesia services	<ul style="list-style-type: none"> • Must be completed prior to surgery • No H&P needed for local anesthesia • OB’s – may substitute prenatal record. If turns into surgical, need H&P prior to surgery 	
History & Physical (greater than 30 days)	Full H&P (not just an update) must be done within 24 hours of admission to inpatient or observation status, but prior to surgery or procedure requiring anesthesia services		
Consultation Report	Documented within 24 hours of consultation		
Post-Op Progress Note	Documented immediately post op		
Provider Coding Query	1) Inpatient: Documented response no later than 7 days post notification to the provider 2) Ambulatory Clinic: Completed within 72 hours of posting		

Documentation Requirement	Timeframe	Exclusions	Reference
Operative Report	Immediately after the procedure but within 24 hours post surgery		
Intraoperative & Post Anesthesia/Sedation Record	Documented within 48 hours after the procedure but prior to patient being discharged/transferred from the post anesthesia/sedation care area		
Special Studies Report	Documented within 48 hours of the completion of the procedure.	Medical imaging reports within 24 hours of completion of procedure.	
Discharge Summary Report	Documented at the time of discharge/disposition but no later than 48 hours post discharge	Not required for normal vaginal deliveries and normal newborns	CMS 482.24 (c)(2)(viii)[Timing] CMS 482.24 (c)(2)(vii) [Authentication]
Discharge Progress Note / Post Procedure Note	Documented at the time of discharge/disposition and no later than 24 hours post discharge for all admissions less than 48 hours or for normal vaginal deliveries and normal newborns	Post-Op Note marked “Discharge Summary” may be used for stays less than 48 hours	
Death Summary	Documented at the time of death/disposition but no later than 48 hours post discharge		
Transfer Summary 1) EMTALA 2) All Others	Documented at the time of transfer but no later than 24 hours		
Signatures	Authentication of transcribed or scanned reports and progress notes within 7 days from the date of discharge		
Verbal Orders	Dated, time and authentication within 48 hours from order		CMS 482.24(c)(1)(iii) ARS 32-1601 (11)(12)(13)(14)(15) AZSBN Act R4-19-402.B
Disposition Orders	Authenticated within 24 hours of admission		

Documentation Requirement	Timeframe	Exclusions	Reference
Medical Record Completion	30-days of discharge <i>pending outstanding query (if applicable)</i>		CMS 482.24(c)(2)(viii)
Outpatient Clinic Records (Summit Healthcare Association only)	Office encounter closed within 5 business days of patient encounter		
All Clinical Entries	N/A. Must be signed, dated and timed (or by electronic means)		CMS 482.24(c)(1)
Gero-Psychiatry Certification	No later than the 12 th day of hospitalization		CMS Publication 1004-04, Chapter 4, section 10.9
Gero-Psychiatry Recertification	As established by the Hospital's Utilization Review Committee, but no less frequently than every 30 days.		CMS Publication 1004-04, Chapter 4, section 10.9

2.18 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. 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).
- 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. A delinquent record is defined as a medical record that is older than 30-days post discharge.
(Rev. 12/2010)
- c) Medical Records Deficiencies - The Health Information Management (HIM) Department monitors timeliness of documentation and notifies the practitioner of incomplete/delinquent medical records via phone, fax mail or electronic notice. For Summit Healthcare Ambulatory clinics, notification will be indirectly sent to the respective office manager through a compiled list of incomplete medical records and associate documents. If a vacation prevents the practitioner from completing his/her medical records the practitioner must notify the HIM Department in advance of the vacation; otherwise the temporary suspension will remain in effect until the delinquent documentation has been completed.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the practitioner or the practitioner's office must notify the HIM Department.

Exception: Request for deferment from temporary suspension may be granted by the Chief Medical Officer after consultation with the Chief of Staff (or designee) provided the practitioner notified the HIM Department him/her being out of town or ill prior to being placed on suspension. Unforeseen circumstances such as illness, injury, military duty or other personal issue will be reviewed by the Chief of Staff and/or the Hospital CEO. The practitioner will be given one week after his/her return to complete any delinquent records.

- d) Medical Records Suspension/Sanctions If medical records are not completed within the timeframes indicated in this section, practitioners will be suspended 22 days from the date the deficiency is assigned (allocation date). This includes loss of privileges including but not limited to admitting, treating, consulting, surgical and anesthesia privileges in both the inpatient and ambulatory setting, if applicable. A practitioner whose privileges have been suspended under this section shall be allowed to continue to treat his/her patients who were in the Medical Center under their care prior to imposition of the temporary suspension of privileges for the day the suspension was implemented only. Request for deferment from temporary suspension may be granted by the Chief Medical Officer in conjunction with the Chief of Staff (or designee). Notice of temporary suspension will be sent to all appropriate Departments. Upon completion of the delinquent medical records, the practitioner's privileges will be reinstated. When a practitioner is temporarily suspended for a continuous period of 60 days, s/he may be deemed to have voluntarily resigned from the medical/allied health professional staff.

Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Effected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if, all delinquent records have been completed. Thereafter, such practitioners shall have been deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges, the practitioner will be required to reapply for medical staff membership, including the application fee. Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this section entitles a practitioner to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee. Permanent suspensions will be reported to the applicable licensing/certification board and/or federal agency as required by law. Medical Records suspensions greater than 30 days are required to be reported to the National Practitioner Data Bank (NPDB). (Rev. 12/2010)

- e) 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.

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; 06/15

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.

Added 04/15/10

3.2 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.

3.3 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. Medical Staff members will extend professional courtesy to improve patient care by requesting a consultation with direct physician to physician communication, except in extreme extenuating circumstances (e.g. requesting physician is managing a code; requesting physician is in a complicated procedure which he/she cannot stop to make the personal phone call). It should be a rare instance when direct communication does not occur.
 - 1) Consult;
 - 2) Consult and assume care of patient. (Rev. 09/2014)
- b) Consultations are recommended in the following instances:
 - i. When the patient is not a good risk for operation or treatment;
 - ii. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - iii. Where there is doubt as to the choice of therapeutic measures to be utilized;

- iv. In unusually complicated situations where specific skills of other practitioners may be needed;
 - v. In cases in which the patient exhibits psychiatric symptoms;
- c) 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.
- d) Consultations are to be completed within twenty-four (24) hours unless otherwise determined by the providers involved. Results of significant finding(s) should be communicated physician to physician.. Added 09/2009; Rev. 12/2010; Rev 09/2014

3.4 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

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

3.5 Telemedicine Encounters for Non-Procedural Core Privileges

Telemedicine encounters are considered an extension of a provider's granted non-procedure privileges. Telemedicine encounters do not substitute for a physician's daily visit unless granted by the Governing Board for select specialties (i.e. Nephrology, Neonatology, etc.).

SECTION 4. RULES REGARDING SURGICAL CARE4.1 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.
- 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.

4.16 Supervision of Non-Physician First Assistants and Certified Surgical Technicians with Suturing Privileges

Non-physician First Assistants (Registered Nurse First Assistant (RNFA), Physician Assistant (PA), Certified Surgical Technologist First Assistant (CSTFA), etc.) and Certified Surgical Technologists with suturing privileges are considered dependent Allied Health Practitioners (AHP), as defined in the Medical Staff Bylaws, and will be credentialed through the Medical Staff process as delineated in the Medical Staff Bylaws and accompanying documents. The Surgery Department Chairman shall act as the sponsoring physician for these AHPs and the operating surgeon shall act as the AHP's supervisor during the procedure. The operating surgeon agrees to assume responsibility for supervision and monitoring of the AHP's practice during the surgical procedure. A dependent AHP may not perform a task during a surgical procedure unless:

1. It is within the AHP's scope of practice;
2. It is delineated within the AHP's scope of privileges on the AHP's privilege checklist; and
3. If applicable, has been appropriately delegated by the AHP's supervising physician in accordance with applicable law.

The AHP is not authorized to independently perform a surgical procedure or to perform organ transplants. (Added 04/24/2014)

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

SECTION 5. RULES REGARDING ANESTHESIA CARE5.1 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. Prostaglandin 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 SERVICES7.1 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. 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.
- D. Medical direction of the Emergency Department will be provided by the Emergency Department Medical Director.

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 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.

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. When a patient goes to surgery or cardiac cath lab, all physician orders related to nursing and ancillary procedures (with exception of code status which is discontinued) are placed on hold for the duration of the perioperative period. Medication orders are kept active but are not acted upon. If the patient returns to the *same* level of care following surgery, orders (including medical orders) are continued unless the patient had general or neuraxial anesthesia. In that case, medication reconciliation must occur when post-operative orders are written. If the patient is transferred to a higher or lower level of care following surgery, medication reconciliation must also occur when post-operative orders are written. When the patient has sedation for a procedure outside the surgery department, all orders are continued and medication reconciliation is not required

When medication reconciliation contains complex medication orders, the surgeon may communicate with the attending for assistance.

Medication Reconciliation must occur:

- If patient has general or neuraxial anesthesia
- If patient is changing level of care following surgery (i.e. previously Med Surg patient but is returning to ICU)
- If patient is changing level of care within the hospital
- If a patient has general anesthesia for a radiological procedure. Medication reconciliation will be completed by the attending provider.

When in doubt, do a medication reconciliation.

(Rev. 11/09; 10/2014)

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.

SECTION 9. RULES REGARDING OUTPATIENT CLINICS9.1 Narcotics in Clinics

Narcotics will not be stocked in Summit Healthcare outpatient clinics with the exception of walk-in clinics or a clinic with a medication point of care service.

Placard to be displayed in clinics indicating no narcotics onsite except as noted above.

9.2 Emergency Care Services in Off-Campus Locations

Summit Healthcare off-campus locations do not provide emergency services. Outpatient clinics will maintain basic preparedness for an emergency which may include AEDs. All staff shall be trained in BLS, at a minimum, and ACLS is optional for providers.

9.2.1 Appraisal of Persons with Emergencies. During clinic operation hours, qualified personnel will conduct an assessment of the patient to determine if an emergency exists.

9.2.2 Referral When Appropriate. If qualified personnel determines the patient's needs exceeds the outpatient clinic's capabilities, 9-1-1 will be called to arrange for appropriate transfer to Summit Healthcare's emergency department. Basic CPR and first aid will be given until appropriate emergency personnel arrive.

9.2.3 Initial Treatment. Outpatient clinics are expected to provide treatment and stabilization consistent with the complexity of services, the type and qualifications of clinical staff, and the resources available at that location.

SECTION 10 – RULES REGARDING GERO-PSYCHIATRY UNIT

- 10.1 Admissions. All appropriate persons are admitted to the Gero-Psychaitric Program (“Program”) regardless of race, color, creed, and/or economic status. A patient is admitted to the program only by written order of a psychiatrist or licensed physician.
- 10.1.1 Any psychiatrist on the medical staff may admit patients to the Program. Other physicians on the staff may refer patients to a psychiatrist for admission to the Program, and may follow their patient in consultation with the psychiatrist during the hospitalization on the unit.
- 10.1.2 Patients becoming acutely agitated within the general hospital who meet admission criteria will have first priority for bed space in the Program.
- 10.1.3 In an emergency situation where the patient would be difficult to treat on the medical-surgical areas, the gero-psychiatry staff and the attending physician will make the decision where to place the patient.
- 10.1.4 Patients presenting through the Emergency Department who are judged by the Emergency Department physician to be medically stable may be admitted in consultation with the psychiatrist to the Program if admission criteria is met.
- 10.2 Discharge. Discharge from any hospital unit and admission to the psychiatric unit will be by order of the attending physician in consultation with the psychiatrist to the Program if admission criteria is met. Prior to patient discharge, the attending Psychiatrist will complete and transmit to the unit:
- 10.2.1 Discharge order
- 10.2.2 Discharge instruction form or transfer form
- 10.2.3 Psychiatrist discharge note.
- 10.3 Gero-Psychiatrist Responsibilities. A Psychiatrist appropriately licensed and credentialed by the Medical Staff will assess, diagnose, and treat patients face to face. This face to face interaction may be done via interactive telecommunications technology and equipment. The Psychiatrist will participate in individual interdisciplinary treatment planning meetings, program performance improvement initiatives, and medical staff peer review. The Psychiatrist may provide the following specific psychiatric services:
- Psychiatric diagnostic interview examination;
 - Individual psycho therapy
 - Pharmacological management;
 - Neurobehavioral status exams
- 10.3.1 The attending Psychiatrist will conduct an initial comprehensive psychiatric examination within regulatory standard timeframes and document the examination in the patient’s medical record.

- 10.3.2 The attending Psychiatrist will conduct daily follow-up assessments. A progress note for each session will be documented in the medical record.
- 10.3.2 The attending Psychiatrist will attend and participate in interdisciplinary treatment team meetings and management meetings. Immediately following the meeting sessions, the attending Psychiatrist will submit progress notes for placement in the patient's medical record.
- 10.3.3 Following individual patient sessions, the attending Psychiatrist will place new orders, physician certification or recertification, if applicable, and updated treatment plans or reviews in the patient's medical record.
- 10.4 Distant site Psychiatrists. For encounters conducted via interactive telecommunications technology, the distant site Psychiatrist will be credentialed in accordance with the Summit Healthcare Medical Staff Bylaws, Rules and Regulations, and Credentialing Procedures Manual.
 - 10.4.1 The distant site Psychiatrist will ensure secure medical record storage in accordance with patient confidentiality laws.
 - 10.4.2 The distant site Psychiatrist will safely destroy any unnecessary medical record information.
- 10.5 Physician Certification and Recertification for inpatient hospital services. At the time of admission, or as soon thereafter as reasonable and practical, the admitting physician or a medical staff members with knowledge of the case must certify the medical necessity for inpatient gero-psychiatric hospital services. Only a physician may complete the certification or recertification. Recertification is required no later than the 12th day of hospitalization. Subsequent recertifications must be made at intervals established by the Hospital's utilization review committee (on a case-by case basis, if it so chooses), but no less frequently than every 30 days.
 - 10.5.1 The required physician's statement for certification should certify that the inpatient psychiatric hospital admission was medically necessary for either:
 - 10.5.1.1 Treatment which could reasonably be expected to improve the patient's condition; or,
 - 10.5.1.2 Diagnostic study.
 - 10.5.2 The physician recertification should state that:
 - 10.5.2.1 The inpatient psychiatric hospital services furnished since the previous certification or re-certification were, and continue to be, medically necessary for, either, treatment which could reasonably be expected to improve the patient's condition or diagnostic study;
 - 10.5.2.2 The patient continues to need, on a daily basis, active inpatient psychiatric treatment furnished directly by or requiring the supervision of Inpatient Psychiatric Facility (IPF) personnel; and

- 10.5.2.3 The hospital records indicate that the services furnished were intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.
- 10.5.3 The period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment as defined in 10.5.2.1 and 10.5.2.2. If the patient remains in the hospital but the period of "active treatment" ends, Program payment can no longer be made even though the patient has not yet exhausted his benefits. When the period of "active treatment" ends, the physician is to indicate the ending date in making his/her recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his/her recertification, the date on which it resumed.
- 10.5.4 The provider may adopt any method that permits verification of all IPFs requirements to continue treatment (e.g. entered on provider generated forms, in progress notes, or in the related patient medical record). The certification or recertification document must include:
 - 10.5.4.1 An adequate written record of the reason for continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or special or unusual services for cost outlier cases for hospitals under a Prospective Payment System (PPS);
 - 10.5.4.2 The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and
 - 10.5.4.3 Any plans for post-hospital care.
- 10.6 Psychiatric Evaluation. Each gero-psychiatric patient must receive a psychiatric evaluation, initiated upon the written physician order that must:
 - 10.6.1 Be completed within 60 hours of admission;
 - 10.6.2 Include a medical history;
 - 10.6.3 Contain a record of mental status
 - 10.6.4 Note the onset of illness and the circumstances leading to admission;
 - 10.6.5 Describe attitudes and behavior;
 - 10.6.6 Estimate intellectual functioning, member functioning, and orientation; and
 - 10.6.7 Include an inventory of the patient's assets in descriptive, not interpretative fashion.

SECTION 11. DISASTER PLAN RULES**11.1 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.

11.2 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.

11.3 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.

SECTION 12. DISRUPTIVE AND INAPPROPRIATE BEHAVIORS

Summit Healthcare is committed to providing a work environment that is free of all forms of discrimination, harassment and retaliation. Actions, words, jokes or comments based on an individual's gender, pregnancy, race, color, age, religion, national origin, physical or mental disability or any other legally protected characteristic will not be tolerated. Summit Healthcare does not, and will not, tolerate harassment, including sexual harassment, of or by its employees, patients, members of the Medical Staff, members of the Allied Health Professional (AHP) staff, or other individuals in the work environment. Summit Healthcare also prohibits retaliation because an employee has engaged in a protected activity. In addition, harassment can be a violation of local, state, and federal law.

It is also the policy of Summit Healthcare that all individuals within its facilities shall be treated courteously, respectfully, and with dignity. To that end, Summit Healthcare requires all individuals, employees, physicians, and other practitioners to conduct themselves in a professional and cooperative manner in Summit Healthcare facilities or at Summit Healthcare events.

If a medical staff member practicing in a Summit Healthcare facility fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with this Policy. If the medical staff member is also a Summit Healthcare employee, other Summit Healthcare policies, including human resources policies, will also apply.

It is Summit Healthcare's intention that investigations undertaken, proceedings held, actions taken, and data created or produced pursuant to this Policy are: (a) confidential, privileged and subject to all applicable peer review and quality improvement program protections under state and federal laws; (b) not subject to subpoena, discoverable or admissible in evidence in any judicial, administrative, arbitration or mediation proceeding; and (c) undertaken by a peer review body, the Physician Review Committee (PRC) or quality improvement program committee, as appropriate, at the direction of the Medical Executive Committee (MEC).

DEFINITION OF SEXUAL HARASSMENT: Sexual harassment includes unwelcome sexual advances, requests for sexual favors or other sexual conduct which:

- A. Is explicitly or implicitly a term or condition of employment, promotion or job benefits;
- B. Serves as the basis for an employment decision; or
- C. Any other verbal or physical conduct of a sexual nature that has the effect of unreasonably interfering with an employee's work performance or which creates an intimidating, hostile or offensive work environment.

Some of the specific prohibited conduct includes, but is not limited to:

- A. Unwelcome sexual advances, including verbal overtures, as well as uninvited physical contact;

- B. Threats against, or promises to, an individual to induce him or her to perform sexual favors;
- C. Intimidation by way of suggesting a desire for unwelcome sexual relations or physical contact;
- D. Continued invitations to social events outside the workplace after it is made clear that such suggestions are unwelcome;
- E. Use of offensive terms of a sexual nature, or degrading language related to an individual's sex, race, religion, age or other legally protected class;
- F. Jokes or remarks of a sexual, religious or racial nature; and
- G. Sexually offensive materials or pictures in the workplace.

DEFINITION OF DISRUPTIVE CONDUCT: Disruptive Conduct is behavior or conduct on the part of any Medical Staff or AHP appointee that impedes patient care, is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others. Examples of Disruptive Conduct include, but are not limited to:

- A. Threatening or abusive language directed at Summit Healthcare personnel, patients, visitors, physicians, or other members of the medical staff; degrading or demeaning comments regarding Summit Healthcare personnel, patients, visitors, physicians or other members of the medical staff;
- B. Profanity or similarly offensive language while in a Summit Healthcare facility;
- C. Inappropriate physical contact or gestures with another individual that is offensive, threatening, demeaning or intimidating;
- E. Interfering with patient safety or refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, policies or rules and regulations;
- F. Attacks leveled at other appointees to the medical staff which are personal, irrelevant, or go beyond the bounds of fair professional comment;
- G. Abusive behavior to patients, yelling at them or refusing to listen to their legitimate questions and requests.
- H. 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;
- I. Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence;

- J. 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;

EXPECTATION OF COOPERATION: Medical Staff members and AHPs shall cooperate with requests for information made in connection with enforcement of this Policy. Failure to cooperate, including a failure to agree in writing to abide by the standards of conduct expected of all Medical Staff members and AHPs as defined by this policy, shall be construed as a voluntary resignation of appointment and privileges.

PROCEDURE FOR REVIEW AND EVALUATION OF COMPLAINTS OF HARASSMENT OR DISRUPTIVE CONDUCT BY MEDICAL STAFF MEMBERS

1. COMPLAINTS: Reports of Harassment or Disruptive Conduct from a person who observes or who believes he/she has been the victim of Harassment or Disruptive Conduct shall be made in writing and/or through the hospital's reporting system which is forwarded to Quality Management for validation. The complaints shall include a factual description of the incident, including quotations of any offending language used and/or a description of any offensive behavior in objective terms.
 - A. EMPLOYEE-RELATED COMPLAINTS: Employee-related complaints are those that are related to actions of employed medical staff members, or where the alleged conduct has an impact on a Summit Healthcare employee or the Summit Healthcare work environment.

All employee reports of Harassment or Disruptive Conduct shall be submitted to Quality Management for validation and forwarded to the Physician Review Committee (PRC) for resolution in a confidential manner. While no promise of confidentiality shall be made to the complainant, every effort shall be made to maintain confidentiality except as legally or otherwise necessary. If the complaint is made or received through the Human Resources Department, it will be promptly forwarded to Quality Management for validation. Any employee initiating a complaint will not be subject to any form of intimidation, harassment or reprisal as a result of making a complaint. The person making the complaint will be informed in writing that the complaint will be promptly reviewed by Summit Healthcare and Medical Staff leadership. The complainant will also be informed that he/she should report any further events to Quality Resource as well as any intimidation, harassment or retaliation that might be a result of making the complaint.

- B. COMPLAINTS FROM OTHERS: All reports of Harassment or Disruptive Conduct involving a member of the Medical Staff or AHP, other than those that are "employee-related," shall be submitted either through the hospital reporting system or to Quality Management for validation. The Human Resources Director may be asked to participate as a consultant for employed providers only. The person making the complaint will be informed in writing that the complaint will be promptly reviewed by Summit Healthcare and Medical Staff leadership. The complainant will also be informed that he/she should report any further events to

Quality Resource as well as any intimidation, harassment or retaliation that might be a result of making the complaint.

2. REVIEW AND EVALUATION OF COMPLAINT:

- A. INITIAL PROCESS: Upon receipt of the occurrence report or complaint in the web-based program (i.e. Quantros System or written report), Quality Management (QM) shall investigate and validate the occurrence report or complaint. If validated, the information is forwarded to the Physician Review Committee (PRC) for further handling. If the occurrence is not validated, the information is forwarded to the PRC and the physician's name is removed from the tracking mechanism of the occurrence and the occurrence is not included in trending for that provider. The PRC will coordinate a plan and process to review pertinent information, notify and interview the alleged offender and interview other appropriately identified witnesses, as appropriate. A medical staff member or AHP has no right to have legal counsel present during the interview process. In the event a medical staff or AHP member brings legal counsel to the interview, the PRC will immediately terminate the interview. This provision has no effect on the due process rights set forth in the Fair Hearing Plan in the Medical Staff Bylaws or Allied Health Professional Manual. The Chief Medical Officer should be included in the planning process if the alleged offender is an employed medical staff member.

In evaluating the complaint, the PRC may ask the alleged offender to provide information regarding the complaint. He/she shall also be informed that retaliation, even subtle retaliation, will not be tolerated. In the event the alleged offender retaliates against the complainant, the alleged offender may be barred from Summit Healthcare facilities by the Chief of Staff, after consultation with PRC pending further investigation. In addition, in the event the complaint is sufficiently egregious, the alleged offender may be barred from all Summit Healthcare facilities by the Chief of Staff after consultation with the PRC pending resolution of the matter.

After completion of the interviews and other applicable inquiry, the PRC and, if employee-related and recommended or requested the Human Resources Director or designee, shall determine whether the report is credible. The Chief Medical Officer should be included in the evaluation process if the alleged offender is an employed medical staff member. If the report is determined not to be credible and if the alleged offender had been informed of the complaint, he/she shall be informed that the complaint was not substantiated. The PRC shall coordinate appropriate feedback to the employee or person who made the complaint.

- B. PLAN TO RESOLVE COMPLAINT: The PRC, the Human Resources Director (in employee-related cases and recommended or requested), and the Department Chairman shall confer and develop a plan for resolution of the complaint. In developing the plan, the decision makers shall consider whether the alleged conduct may be a product of an impairment or another health problem (and therefore subject to resolution under the Wellness Policy), whether the alleged

conduct may constitute Harassment or Disruptive Conduct, the severity of the conduct, the impact on patient care, the nature and type of previous conduct allegations, previous actions taken by Summit Healthcare against the alleged offender, and other pertinent information. The PRC shall determine whether informal action under this Policy or formal action is warranted. Any single egregious occurrence may result in the occurrence being forwarded to the Medical Executive Committee (MEC) for formal action.

3. RESOLUTION OF COMPLAINT AND DISCIPLINARY ACTION:

A. INFORMAL ACTION:

1) **FIRST EVENT:** If a single occurrence warrants informal action under this Policy, the Department Chairman and/or designee(s) (e.g. Chief Medical Officer) shall meet with the alleged offender to discuss the complaint. This Policy and any other applicable policies shall be discussed with the offender. The conversation shall be documented, a copy of which shall be filed in the Medical Staff Credentials/Peer Review file. In cases where the conduct is sufficiently egregious to warrant greater intervention, the offender shall be told that a single further incident of Harassment or Disruptive Conduct will result in initiation of formal disciplinary action pursuant to the Medical Staff Bylaws. A letter to the offender describing these expectations may be sent to the practitioner and shall be filed in the Medical Staff Credentials/Peer Review File. If employee-related and the Human Resources Director or designee has not been involved in the planning process, the PRC will inform the Human Resources Director that the issue has been addressed.

2) **SECOND EVENT:** If additional incidents of Harassment or Disruptive Conduct are reported, they will be evaluated according to the process described above.

If substantiated, the Chief of Staff or designee and at least one of the following shall discuss the matter informally with the medical staff member: Department Chairman, Chief Executive Officer and/or Chief Medical Officer. The conversation shall be documented in a letter to the offender, a copy of which shall be filed in the Medical Staff Credentials/Peer Review File. The letter shall state that the medical staff member is required to correct the inappropriate behavior and cooperate with the resolution of the problem that his/her behavior caused. If employee-related and the Human Resources Director has not been involved in the planning process, the PRC will inform the Human Resources Director that the issue has been addressed.

3) **THIRD EVENT:** If additional incidents of Harassment or Disruptive Conduct are reported, they will be evaluated according to the process described above.

If confirmed, the Chief of Staff, the Chief Executive Officer and/or the Chief Medical Officer, and the Department Chairman shall meet with and advise the medical staff member that such conduct is intolerable and must stop. A member of the Governing Board may participate in the meeting. This shall be followed with a letter reiterating the conditions applicable to continued appointment, a copy of which shall be filed in the Medical Staff Credentials/Peer Review file. The Medical Executive Committee shall be informed. If employee-related and the Human Resources Director has not been involved in the planning process, the PRC will inform the Human Resources Director that the issue has been addressed.

- 4) **SUBSEQUENT EVENT:** A single additional confirmed incident shall result in initiation of formal disciplinary action pursuant to the Credentials Policy.

- B. **FORMAL ACTION:** If formal action is deemed to be warranted by the Chief of Staff after consultation with the PRC at any time, the matter shall be referred to the Medical Executive Committee for action pursuant to the Medical Staff Bylaws. Suspension of the offender may be appropriate if warranted.

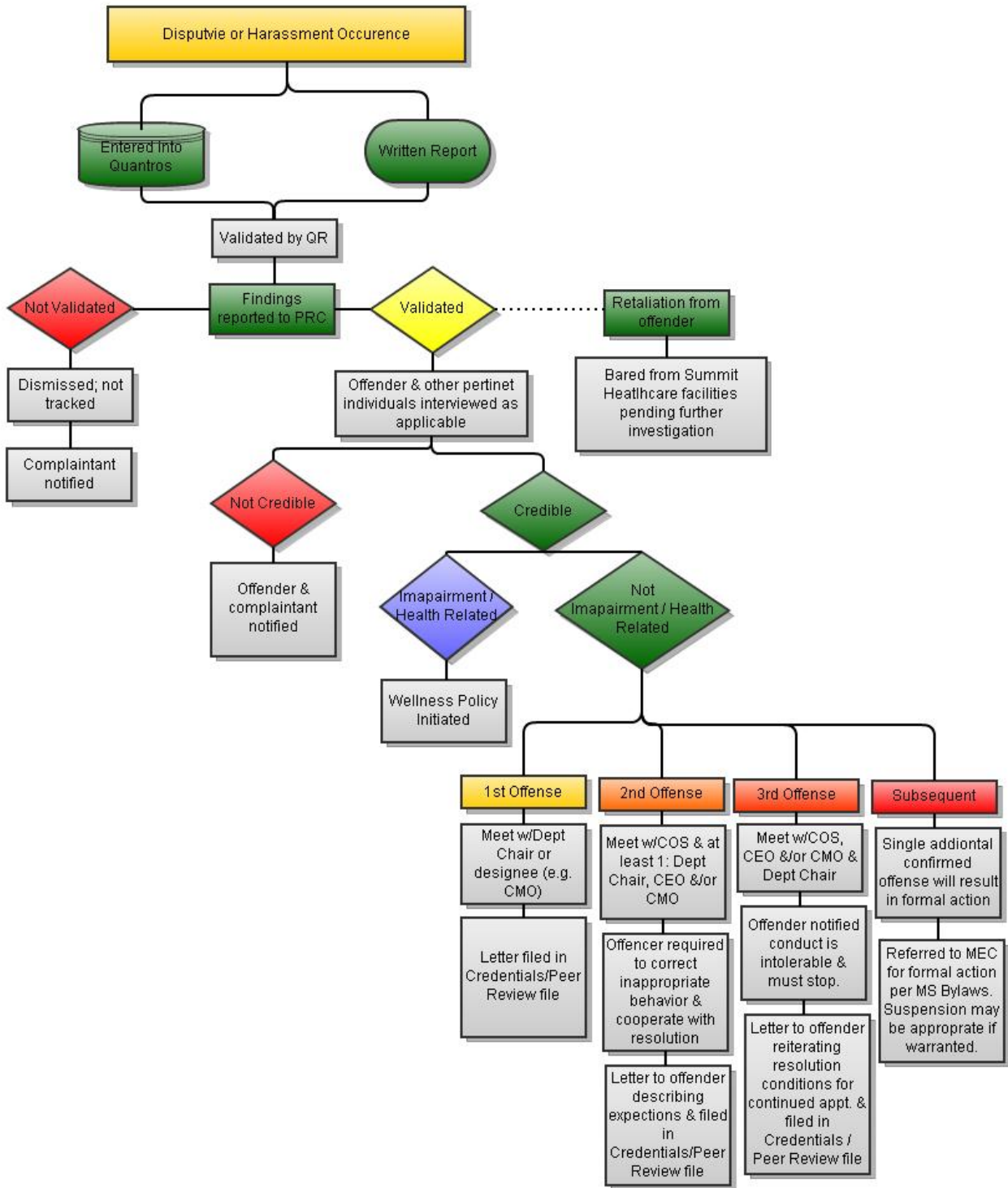
4. **TRENDING OF OCCURRENCES**

The resolution of complaint and disciplinary action steps will start over with the first step if there are no other offenses within two (2) full reappointment terms.

(Rev. 02/2013)

Disruptive & Inappropriate Behavior Flow Chart

*Please refer to text for policy specifics



SECTION 13. PROFESSIONAL STAFF WELLNESS POLICY**13.1 Purpose:**

To establish the steps to be taken in the event a Professional Staff is suspected of having a drug, alcohol, psychological, medical or other impairment. This policy creates a process that allows Professional Staff 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.

13.2 Definitions:

13.2.1 "Professional Staff" shall mean a physician, dentist or podiatrist who is a member of the Medical Staff or Allied Health Professional Staff.

13.2.2 "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.

13.3 Process:

13.3.1 Any individual working in the hospital who has a good faith belief that a Professional Staff 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. Professional Staff should contact the unit supervisor.

13.3.2 If the supervisor concurs, the supervisor shall immediately contact the Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee,. 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.

13.3.3 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.

13.3.4 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).

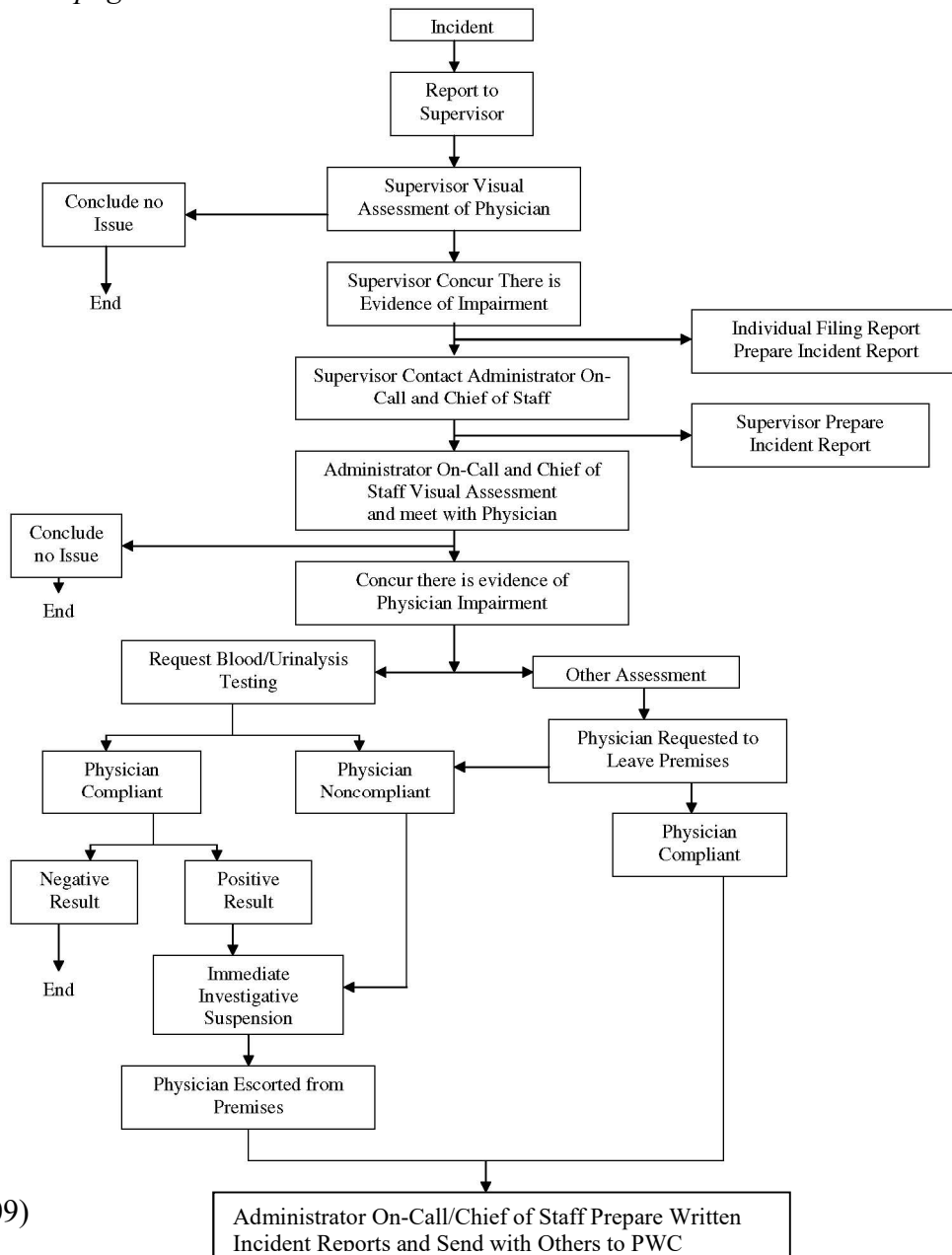
- 13.3.5 Where the Administrator on call and/or the Chief of Staff have a good faith basis to believe a Physician was in the Hospital, or otherwise treating Hospital patients, while impaired, they shall immediately contact the chairperson of the Medical Staff Physician Wellness Committee ("PWC").
- 13.3.6 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.
- 13.3.7 If in the reasonable belief of the PWC, the Physician requires a psychological, medical or other assessment, the following process will be implemented:
- 13.3.7.1 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").
- 13.3.7.2 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.
- 13.3.7.3 The Physician will execute a Physician Support Agreement with the PWC in the same or similar format as that provided in Attachment "A."
- 13.3.8 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.
- 13.3.9 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."
- 13.3.10 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.

13.3.11 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.

13.3.12 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.

13.4 Physician Wellness Policy Flowchart

See next page



(Rev. 10/09)

SECTION 14. 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:

14.1 Interpersonal Relationships

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

14.2 Patient-centered Care

- 14.2.1 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.
- 14.2.2 When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- 14.2.3 Provide patient care that is professional and within the scope of privileges, education, and training
- 14.2.4 Respond professionally and in a timely manner when called upon by fellow practitioners to provide appropriate consultation or clinical services

14.3 Safety

- 14.3.1 Participate in quality measures identified to improve patient safety
- 14.3.2 Participate in the organization's efforts to improve safety from a systems perspective by identifying and reporting potential performance improvement initiatives
- 14.3.3 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

14.4 Professional Practice

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

14.5 **Disruptive and Inappropriate Behaviors**

Disruptive Physician and Inappropriate Behaviors are defined and addressed in the Medical Staff Rules and Regulations.

(Added 04/2009)

SECTION 15. PEER REVIEW POLICY & PROCEDURE

15.1 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.

15.2 Confidentiality, Immunity, and Compliance With State Law:

All written records of interviews, reports, statements, minutes, memoranda, and all physical and electronic 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 Association and its 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.

15.3 Definitions

15.3.1 *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.

15.3.2 *Scope of Peer Review*: All Summit Healthcare Association patient cases are candidates for Peer Review. Patient cases are routinely selected for Peer Review

through 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.

15.3.3 *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) as identified by the Peer Review Body, a peer is an individual who is well-trained and competent in an applicable specialty. *Physicians are required to actively participate in Medical Peer Review (Credentialing Procedures Manual Section 3.13.6). Allied Health Professionals are subject to the same peer review policy concurrently with their supervising physician. Case(s) are to be reviewed by another physician and/or Allied Health Professional at the discretion of the Peer Review Body.

15.3.4 *Peer Review Body*: The Peer Review Body is designated to perform the initial review by the Medical Executive Committee (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/Medical Staff Conflict of Interest). A function of the Peer Review Body is to determine level of technical expertise needed for Peer Review.

15.3.4.1 *Membership*. Committee membership will consist of one representative from each Medical Staff Department and Members-At-Large as nominated by and approved by the Medical Executive Committee, and the Summit Healthcare Chief Medical Officer, unless otherwise designated for specific circumstances by the MEC. The Medical Staff Treasurer shall serve as an ex-officio member of the Peer Review Committee. Each Department will elect its own representative from among its membership.

15.3.4.2 *Term* of Committee membership shall be as follows:

- a. Department Representative - a two (2) year renewable term; and
- b. Member-at-Large – a three (3) year renewable term

15.3.4.3 *Chairman*. The Peer Review Body Chair will be appointed by the Medical Executive Committee. The Peer Review Body Chair must be a member of the Active Medical Staff in good standing and have served on the Committee at least two (2) years. The Peer Review Body Chair shall serve a two (2) year renewable term.

If the Chief of Staff involvement in peer review is needed, the Chief of Staff or designee shall be called upon to provide direction.

15.3.5 *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, or their designee, or combination of as needed. Documentation of an Early Intervention will be reported to the Peer Review Body for informational purposes and will be held in Medical Staff Services. The Early Intervention may be considered at time for reappointment/provisional review.

- 15.3.6 *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
- 15.3.7 *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 but are not all inclusive:
- 15.7.1 Additional education/CME with proof of completion
 - 15.7.2 Prospective monitoring/review of next (set by MEC) cases.
 - 15.7.3 Retrospective review/proctoring for identified issues.
 - 15.7.4 Concurrent Proctoring for identified issues.
 - 15.7.5 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.
 - 15.7.6 Additional Training in identified area. Program will be approved by MEC and completed by date set.
 - 15.7.7 Educational Leave of Absence.
- 15.3.8 *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. The Medical Staff Conflict of Interest Guidelines (Section 15) will be utilized 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.
- 15.3.9 *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.
- 15.4 **Guidelines**
- 15.4.1 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 non-discoverability.
 - 15.4.2 The involved practitioner receives provider-specific feedback on a routine basis.
 - 15.4.3 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.

- 15.4.4 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
- 15.4.4.1 Performance data for all dimensions of performance measured for that individual physician
 - 15.4.4.2 The individual physician's role in sentinel events, significant events, or near misses
 - 15.4.4.3 Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action in the form of a PIP.
- 15.4.5 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.
- 15.4.6 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 Chief Quality Officer or designee. Only the following individuals have access to provider-specific peer review information, and only for purposes of quality improvement:
- 15.4.6.1 The specific provider
 - 15.4.6.2 Medical Staff Officers
 - 15.4.6.3 The Medical Staff Peer Review Body
 - 15.4.6.4 Medical staff department chairs (for members of their departments only)
 - 15.4.6.5 Members of the medical executive, credentials, and quality committees
 - 15.4.6.6 The Chief Quality Officer and staff supporting the peer review process
 - 15.4.6.7 Medical staff services professionals, to the extent that access to this information is necessary for the re-credentialing process or formal corrective action
 - 15.4.6.8 Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., federal or state regulatory bodies)
 - 15.4.6.9 Individuals with a legitimate purpose for access as determined by the hospital board of directors

15.4.6.10 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.

15.4.7 No copies of peer review documents are created and distributed unless authorized by the MEC, the Governing Board, or by the Chief of Staff for purposes of deliberations regarding corrective action on specific cases.

15.5 **Circumstances Requiring Peer Review**

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. Additional evaluations are conducted when there is a sentinel event, a near miss, or an unusual individual case. (Rev. 04/2013)

15.6 **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, Chief Quality Officer, or any administrator over employed or contracted providers. 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 six (6) working days from receipt of hand delivered notification or certified letter. If clinical support staff is unable to had deliver the notification within five (5) working days, a certified letter shall be sent.

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.

15.7 **Threshold for Intensive Review**

15.7.1 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.

15.7.2 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.

15.7.3 Thresholds:

15.7.3.1 Any single egregious case

15.7.3.2 Within any 6-month period of time, any one of the following criteria:

15.7.3.2.1 Two cases with physician clinical judgment or decision-making; diagnoses, or with issues identified with technical skills

- 15.7.3.2.2 Four cases with identified issues related to communication, documentation, follow through and other related issues

15.8 Peer Review for Specific Circumstances

In the event that a decision is made by the MEC 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.

15.9 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.

15.10 Oversight and Reporting

Direct oversight of the peer review process is delegated by the MEC to the Quality Initiative subcommittee: the Peer Review Body. A report is generated for MEC and the Governing Board at least quarterly.

15.11 PEER REVIEW INDICATORS

15.11.1 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 Summit Healthcare. Routine Peer Review Indicators are automatically sent for review and do not typically proceed through the Peer Review Body.

15.11.2 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.

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

15.11.3.1 A Sentinel Event (A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.)

15.11.3.2 A significant 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.)

- 15.11.3.3 The request for a review from at least two of the following: the Chief of Staff or designee, Risk Management, the Corporate Compliance Officer, the Department Chairman, the Chief Medical Officer, and/or the Chief Quality Officer. (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, may from time to time, establishes additional Extraordinary Peer Review Indicators to be used to select cases for review.

- 15.11.4 Expedited Review of Cases with Extraordinary Peer Review Indicators. For case(s) identified by or reported to Quality Management staff with significant concerns and/or the potential for patient harm, an Expedited Review Pathway, which is on file in Medical Staff Services and Quality Management Office, shall be followed. Any case involving Extraordinary Peer Review Indicators, at the discretion of the Chief of Staff or designee and Department Chairman or designee, 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. In the event of Department meeting cancellation or untimely meeting, the case may be referred to the next MEC for review or special MEC or Department meeting may be called in order to provide for expedited review.

15.12 PEER REVIEW RESULTS

15.12.1 A Peer Quality Review Form is completed for each peer review done.

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

- 14.12.2.1 No further follow-up needed.
- 14.12.2.2 Department review of identified issues and actions needed.
- 14.12.2.3 Cases referred to Department Peer Review combines the peer review process with a comprehensive review of the system issues surrounding the care in question. Cases may be reviewed at the Division level at the discretion of the Department Chair with the Department Chair to be in attendance during the peer review process.
- 15.12.3 Cases referred to the Department Peer Review with nursing issues requests that the CNO and appropriate Nursing Director be present for the review.
- 15.12.4 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.

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

15.13 DEPARTMENT PEER REVIEW AND REFERRAL PROCEDURE TO MEC

- 15.13.1 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.
- 15.13.2 The Department Chair 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 once 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. The involved physician submits any reviewing concerns in writing prior to the scheduled Department review.
- 15.13.3 The Department Chairman and membership may request closure of the peer review, actions in the form of an educational letter or a collegial intervention related to the issues identified, recommend a Performance Improvement Plan (PIP) be created if warranted, and/or request further review by the Peer Review Body or MEC.
- 15.13.4 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.
- 15.13.5 The actions of the Department are reported to the Peer Review Body. The Peer Review Body may close the case, recommend a Performance Improvement Plan (PIP) be created if warranted, and/or the case may be sent to the MEC. The MEC is solely responsible for approval and implementation of PIPs. All actions taken are reported back to the Peer Review Body for closure.
- 15.13.6 If a PIP is implemented and the physician being reviewed disagrees with the PIP, 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.

15.14 RECORDING AND USE OF PEER REVIEW RESULTS

- 15.14.1 Upon completion of the Peer Review, the patient case medical record and the completed Peer Review Form are returned to the QM Department for completion.
- 15.14.2 Peer Review final results are aggregated with identified issues and submitted to the Credentialing Committee with documentation of completed actions.

- 15.14.3 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)

15.15 **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).

- 15.15.1 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 Peer Review Body Chairperson.
- 15.15.2 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).

SECTION 16. MEDICAL STAFF CONFLICT OF INTEREST GUIDELINES

16.1 GENERAL PRINCIPLES

16.1.1 All those involved in credentialing and professional practice valuation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

16.1.2 It is also essential that *peers* participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

16.2 IMMEDIATE FAMILY MEMBERS

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

16.3 EMPLOYMENT OR CONTRACTUAL RELATIONSHIP WITH THE MEDICAL CENTER

Employment by, or other contractual arrangement with, the Medical Center or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

16.4 ACTUAL OR POTENTIAL CONFLICT SITUATIONS:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

- 16.4.1 membership in the same group practice;
- 16.4.2 having a direct or indirect financial relationship;
- 16.4.3 being a direct competitor;
- 16.4.4 close friendship;
- 16.4.5 a history of personal conflict;
- 16.4.6 personal involvement in the care of a patient which is subject to review;
- 16.4.7 raising the concern that triggered the review; or
- 16.4.8 prior participating in review of the matter at a previous level.

Any such individual shall be referred to as an “Interested Member” in the remainder of this Section for ease of reference.

16.5 GUIDELINES FOR PARTICIPATION IN CREDENTIALING AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

16.5.1 Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

16.5.1.1 participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and Medical Executive Committee's subsequent review of credentialing matters; and

16.5.1.2 participation as case reviewers in professional practice evaluation activities because of the Peer Review Committee's subsequent review of peer review matters.

16.5.2 Credentials Committee or Peer Review Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal below.

16.5.3 Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

16.5.4 Medical Executive Committee. An Interested Member will be recused and may not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

16.6 GUIDELINES FOR PARTICIPATION IN DEVELOPMENT OF PRIVILEGING CRITERIA:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

- 16.6.1 provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;
- 16.6.2 serve on the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Credentials Committee Chair or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but
- 16.6.3 not serve on the Medical Executive Committee when it is considering its final recommendation to the Governing Board regarding the criteria.

16.7 RULES FOR RECUSAL

- 16.7.1 When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair will consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee or would skew the recommendation or determination of the committee.
- 16.7.2 Any Interested Member who is recused from participating in a committee meeting must leave the meeting room prior to the committee's final deliberation and determination, but may answer questions and provide input before leaving.
- 16.7.3 Any recusal will be documented in the committee's minutes.
- 16.7.4 Whenever possible, an actual or potential conflict should be brought to the attention of the Chief of Staff or committee chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

16.8 OTHER CONSIDERATIONS

- 16.8.1 Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict), or the applicable committee chair. The member's failure to notify will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee chair has the authority to make a final determination as to how best to manage the situation, guided by this Section, including recusal of the Interested Member, if necessary.
- 16.8.2 No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff leaders, guided by this Section.

16.8.3 The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

MEDICAL STAFF CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation						
	Provide Information	Individual Reviewer Application/ Case	Committee Member				Hearing Panel Member
			Credentials	Peer Review	MEC	Ad Hoc Investigating	
Family Member	Y	N	R	R	R	N	N
Employment relationship with the hospital	Y	Y	Y	Y	Y	Y	Y
Partner	Y	E	E	E	R	N	N
Direct or indirect financial impact	Y	E	E	E	R	N	N
Competitor	Y	E	E	E	R	N	N
History of conflict	Y	E	E	E	R	N	N
Close friends	Y	E	E	E	R	N	N
Personally involved in care of patient	Y	E	E	E	R	N	N
Reviewed at prior level	Y	E	E	E	R	N	N
Raised the concern	Y	E	E	E	R	N	N

Y – No conflict; E – Evaluate for conflict; R – Recuse; N - Conflict

Individual Reviewer Safeguards (Credentialing) – Yellow boxes

- Objective threshold criteria for appointment/privileges
- Objective review/evaluation form
- All questions/concerns referred to Credentials Committee
- Credentials Committee/MEC check and balance

Individual Reviewer Safeguards (Focused Professional Practice Evaluation)(Peer Review) – Yellow boxes

- Objective review/evaluation forms
- Objective criteria to review against
- Peer Review check and balance

Credentials Committee/Peer Review Member Safeguards – *Yellow boxes*

- MEC check and balance
- Credentials/Peer Review Chair always has discretion to recuse member in particular situation subject to the rules of recusal

Rules for Recusal – *Orange boxes*

- When determining whether recusal is required, the Chief of Staff or committee chair shall consider whether the Interested Member's presence would inhibit the full and fair discussion of the issue before the committee or would skew the recommendation or determination of the committee
- Interested Member must leave meeting room prior to committee's final deliberation and determination but may answer questions and provide input before leaving
- Recusal shall be documented in minutes
- Whenever possible, actual or potential conflict should be raised and resolved prior to meeting by committee chair and Interested Member informed of the recusal determination
- No staff member has a RIGHT to demand recusal – within discretion of Medical Staff leaders
- Choosing to refrain from participation is not a finding of actual conflict

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:

November 19, 2019
Dated

Approved by the Governing Board on:

November 21 2019
Dated