DEACONESS HENDERSON HOSPITAL

MEDICAL STAFF

GENERAL RULES AND REGULATIONS

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DEACONESS HENDERSON HOSPITAL
Henderson, KY

GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

I. ADMISSION AND DISCHARGE

Section 1. Who May Admit Patients

A patient may be admitted to the hospital only by individuals who have been appointed to the medical staff and who have been granted privileges. Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 2. Transfer of Patients

Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by the patient or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or attending medical staff member, or both, shall assist the patient in making arrangements for care in an alternative facility so as not to jeopardize the health and safety of the patient. If the patient is to be transferred to another health care facility, the responsible medical staff member shall enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

Section 3. Responsibility of Medical Care

Each patient shall be the responsibility of a designated medical staff member (“attending physician”). Such medical staff member shall be responsible for the medical care and treatment, 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 provider and the patient's family when appropriate. Whenever these responsibilities are transferred to another medical staff member, an order covering the transfer of responsibility shall be entered on the order sheet and, when practical, a note discussing the transfer written in the progress notes of the patient's medical record, whereupon the medical staff member to whom the patient has been transferred shall acknowledge the transfer, and shall be responsible for the care of that patient until the patient is discharged from the hospital. The attending physician shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients, or hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm.

The attending physician shall be responsible for performing a personal evaluation of every patient admitted to his/her service at least once during the patient’s hospital stay except for

psychiatric services which may delegate responsibility to Qualified Medical Personnel or Care Team as defined by Psychiatric Department Policy. A note from the attending physician shall be placed in the patient's electronic medical record to signify such visit. Daily progress notes may be written by the physician's Nurse Practitioner or Physician's Assistant.

Consulting physicians shall also be responsible for performing a personal evaluation on every hospitalized patient for whom a formal consult has been requested for their specialty services, subject to the exception for psychiatric services as described above. A consult is initiated by the provider by placing an order in the Electronic Health Record (EHR). This order may be accompanied by adding the consultant to the treatment team in the EHR after direct provider to provider communication. Direct discussion between the provider and the consultant is required for all EMERGENT or STAT consultations.

Section 4. Alternate Coverage

A. Each medical staff member shall provide assurance of immediate availability of adequate professional care for his/her patients in the hospital by being available personally or having available an alternate medical staff member with whom prior arrangements have been made and who has appropriate clinical privileges at the hospital sufficient to care for the patient. Failure to meet this requirement may result in corrective action.

B. In cases where the attending medical staff member is unavailable and there is failure to arrange for alternate coverage, the Chief of the appropriate medical staff department or his or her designee shall have the responsibility for the patient and/or authority to assign care of the patient to another staff member.

Section 5. Emergency Admissions

In the case of emergency admissions, patients who do not have a personal physician with admitting privileges will be assigned to the medical staff member on call with privileges in the specialty which the diagnosis indicates or to an established admitting service.

Section 6. Discharges

Patients shall only be discharged on the order of the attending physician or other responsible provider. At the time of discharge, the physician or other responsible provider shall see that the medical record is as complete as possible.

Section 7. On Call

When a physician is on service call, that physician is responsible for all calls within the entire medical complex including the Emergency Room and all other clinical areas.

A physician who is providing call coverage must be quickly available by telephone to consult with the ED physicians providing services in the ED and must respond within a reasonable amount of time which is generally considered to be one hour or less when asked to come to the ED to examine and provide stabilizing treatment for a patient with an emergency medical condition. In the event the physician fails to respond within a reasonable period of time, the ED Physician will present the situation to the appropriate department or section chief and/or president-elect or president of the

medical staff to obtain appropriate specialty services. If appropriate specialists are not available, the administrator of the hospital who is on call will provide direction to the ED. This is in effect 24 hours a day, 7 days a week. A qualified medical provider will provide the needed service to the ED patient to meet the EMTALA requirements of a medical screening exam. See Hospital Policy and Procedure No. 90-158H and 90-160H ("EMTALA Guidelines") for further guidance.

II. MEDICAL ORDERS

Section 1. General

All orders for treatment must be in writing, legible, complete, and free of unapproved abbreviations. Orders entered in the patient's record must be dated, timed and authenticated by the responsible practitioner or advanced practice provider within his or her license and scope of practice. Orders which are illegible or improperly written will not be carried out until rewritten or clarified as a verbal order which is read back and verified by the nurse.

Section 2. Pre-Printed Orders

Pre-printed orders, when applicable to a given patient, shall be reproduced in detail on an order sheet of the patient's record, dated, timed and authenticated by the staff member. Pre-printed orders are subject to review by the appropriate department, committee and/or Medical Staff Executive Council.

Section 3. Verbal Orders

Verbal orders (either in person or via telephone) for medication or treatment shall be accepted only under urgent circumstances when it is impractical for such orders to be given in written manner by the responsible provider. Verbal orders shall be given only to qualified personnel who shall read back the order to the provider giving it, thereby verifying its accuracy. The order shall include the date, time and name of the person taking the order and shall be authenticated by the ordering provider or a member of his/her group within 30 days of the patient's discharge from the hospital. Qualified personnel include a registered nurse; a licensed practical nurse; a pharmacist; a respiratory therapist; an occupational therapist; a physical therapist; a speech therapist; a recreation therapist; laboratory staff; a dietitian; a radiology technician; a social worker; diabetes clinician, medical student and bed assignment personnel limited to the use of admission status. The above listed qualified personnel may only accept verbal orders within their area of expertise.

Section 4. Automatic Stop Orders

All previous orders are cancelled for patients undergoing surgery.

Section 5. Orders for Restraint or Seclusion

Refer to Hospital Policy and Procedure No. 40-19.

Section 6. Consultations Required

Orders for consultation are required when patients present with morbidities and/or co-morbidities outside the field of practice of the admitting physician; when the diagnosis is uncertain; and when the patient's condition fails to improve as would otherwise be expected given the patient's diagnosis

and treatment within forty-eight (48) hours. Collegial discussion of a case and/or informal request of advice from another provider can be very beneficial for the care of the patient. This interaction is not considered a "consult" by this medical staff, so if the inquiring physician desires that the patient have further assessment, a request for consultation should be communicated to the physician or his/her representative who is receiving the request for consult, and the consult must be placed in the EHR as an order or by listing the provider on the patient's treatment team.

Section 7. Critical Care Medicine Specialists

Critical Care Medicine Specialists, (either on-site or via telemedicine), are authorized to diagnose, treat, and write orders for any patient in the Intensive Care Unit.

ICU Patients and Critical Care Physician Access:

All patients who are admitted for any reason to the ICU at Deaconess Henderson Hospital will trigger a call to the attending Pulmonary/Critical Care physician on duty to be evaluated for possible need for their involvement with that patient's care. If the Critical Care physician determines it's appropriate for his/her involvement, they will self-initiate a consultation autonomously, and that physician will promptly call/notify the admitting physician directly to collaborate care.

If the Critical Care physician determines no indication for his/her involvement, the ICU nurse will document in the chart the call was made and that the physician determined Critical Care involvement was not medically indicated. The Critical Care physician retains the autonomy and authority to involve him/herself in the care of any ICU patient, at any time, at will.

Section 8. Referring Practitioners

A practitioner who is not a member of the medical staff or not an allied health care provider with clinical privileges who wishes to order an out-patient infusion, laboratory test, radiological examination, occupational therapy, physical therapy, or speech therapy for his or her patient to be performed at Deaconess Henderson Hospital will provide his/her office address, telephone number, NPI number, and valid order. This will also apply for orders from a provider for a therapeutic infusion/injection of a substance in the outpatient infusion center. If the order is for chemotherapy/immunotherapy and is from a referring practitioner that holds clinical privileges at a different Deaconess Health System affiliated facility, the order will be accepted for treatment. A Deaconess employed pharmacist will review the therapeutic infusion/injection order and sign the order in the EHR after the order/process has been verified with the referring practitioner. The referring practitioner cannot provide care/new orders for the patient while receiving treatment at a Deaconess facility in which they do not hold clinical privileges, instead the practitioner providing clinical oversight of the infusion center would be contacted in a needed situation. An IT ticket will be entered by the auth or scheduler team and IT Cadence will verify NPI number, current license, and screen exclusion list prior to adding the provider to the system ad prior to billing.

Section 9. Therapy Orders

Physical therapists, occupational therapists and speech therapists have the authority given to them by the medical staff to evaluate, develop a plan of care and implement the plan.

III. MEDICAL RECORDS

Section 1. General

A. The attending medical staff member shall be responsible for the preparation of a complete and legible medical record for each individual who is evaluated or treated as an inpatient, ambulatory care patient, observation patient or emergency patient. The contents of the record shall be pertinent and current.

B. Only those abbreviations, signs and symbols authorized by the medical staff shall be used in the medical record. Unapproved abbreviations shall not be used in the medical record. No abbreviations, signs, or symbols shall be used to record a patient's final diagnosis or any unusual complications.

Section 2. Authentication

All entries in the record shall be dated, timed and authenticated by the person who is making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Authentication may be by written signatures or initials, rubber-stamp signatures or electronic signature. When rubber-stamp signatures are authorized, the individual whose signature the stamp represents signs a statement that he/she alone will use the stamp. This statement is filed in the Medical Records Department. Such a stamp cannot be used by another individual. When electronic signatures are being used, practitioners shall not share their user ID or password or other hospital-approved form of authentication.

Limitations on the ability of residents to write orders shall be specified in the Residency Training Program.

Section 3. Contents

A. A complete inpatient medical record shall include:
   1. Identification data, including the patient's name, address, date of birth, social security number and next of kin
   2. Date of admission and discharge
   3. Medical history, including chief complaint; details of present illness; relevant past, social and family history; and inventory of body systems
   4. Provisional admitting diagnosis
   5. Report of a physical examination or a note as to the contraindications for such an examination or valid reasons why the exam was not performed.
   6. Statement of the conclusions or impressions and the treatment plan drawn from the admitting H&P
   7. Diagnostic and therapeutic orders
   8. Evidence of appropriate informed consent – Refer to Hospital Policy and Procedure No. 50-51 S
      - Obtaining Informed consent for any procedure can be delegated to a collaborating advanced practice provider with the proceduralist, as long as the physician

responsible for the procedure documents an explanation of risks and benefits has been done by him or her directly with the patient prior to the procedure

9. Clinical observations, progress notes, nursing notes, consultation reports
10. Reports of procedures, tests, and the results, including operative reports
11. Reports of pathology and clinical laboratory exams, radiology and nuclear medicine exams or treatment, anesthesia records and any other diagnostic or therapeutic procedures
12. Conclusions at termination of hospitalization, including the provisional diagnosis or reasons for admission, the principal and additional diagnoses, the clinical resume or final progress note, and (when appropriate) the autopsy report
13. Limitations on the ability of residents to write orders shall be specified in the Residency Training Program.

B. All medical record forms shall be standardized and submitted to the Medical Record Committee for review.

Section 4. History and Physical Examination

A medical history and physical examination shall be completed and in the medical record on each inpatient, ambulatory surgery patient or patient in outpatient observation status within 24 hours of admission or outpatient registration, as applicable. This time frame applies for weekend, holiday and weekday admissions. A durable, legible original or reproduction of a medical history and a completed physical assessment, obtained by the responsible provider, completed within 30 days before admission, is acceptable provided that it is accompanied by an update performed within 24 hours of admission or outpatient registration and prior to surgery or a procedure requiring anesthesia services. It is also acceptable for the history and physical to have been performed within 30 days before admission or outpatient registration by a referring physician who is not a member of the medical staff, so long as it is reviewed and updated by the responsible provider within 24 hours of admission and prior to surgery or a procedure requiring anesthesia services. See Section VII.L. of the Medical Staff Bylaws.

Certified physician assistants, certified nurse-midwives and nurse practitioners may write or dictate histories and physicals in patients' charts if granted such authority by the medical staff with the approval of the governing body. Histories and physicals performed by physician assistants, nurse-midwives and nurse practitioners must be countersigned by a physician.

Histories and Physicals may be performed by Podiatrists without countersignature by a physician so long as the patient does not remain in the hospital overnight. The heart, lung, and airway assessment will continue to be completed and documented by Anesthesia prior to surgery in their pre-operative record.

When the history and physical examination are not recorded before an operation or any procedure requiring anesthesia services, the procedure shall be cancelled unless the attending medical staff member states in writing that such a delay would be detrimental to the patient. In an emergency,

the medical staff member shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

All obstetrical patients who have received prenatal care shall have a copy of the office prenatal history placed on the medical record at the time of admission.

In place of a full history and physical, an assessment of the affected body system and of the cardiac and respiratory system is acceptable for all outpatients who undergo moderate sedation or are placed in overnight observation. Compliance with the timeliness requirement will be measured by use of the "filed time" in the EMR, as that is the time the report is available to others.

Section 5. Progress Notes

Progress notes shall be written daily for all inpatient, ambulatory surgery and observation patients with the exception of those patients admitted to Psychiatric Services where frequency of progress notes is guided by Psychiatric Treatment Policy MS.03 specific to Psychiatric Services. Progress notes should contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment and promote continuity of care among healthcare providers. Progress notes deemed incomplete or absence of daily progress notes will be grounds for review by the Medical Record Committee. If the Committee determines a continuing pattern of incomplete or absent progress notes exists, the provider will be referred to the Medical Executive Council with a corrective plan of action.

Section 6. Operative Reports

A procedure note to include the following must be entered into the medical record at the time of the procedure:

1. Description of the findings
2. Technical procedures performed
3. Specimens removed (if any)
4. Post operative diagnosis
5. Name of primary surgeon and assistants (if any)
6. Complications
7. Estimated blood loss

The operative report shall be completed by the surgeon and is available in the medical record no more than 24 hours after the procedure.

Section 7. Discharge Summary

A clinical discharge summary shall be completed within seven (7) days of discharge on all inpatients except for normal obstetrical deliveries, normal newborn infants and patient stays under 48 hours. In those cases, a final progress note may serve as the discharge summary.

A discharge summary should discuss the outcome of the hospitalization, the disposition of the patient, and provisions for follow up care. Follow up provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes or assisted living.

Certified physician assistants, nurse practitioners or certified nurse-midwives may write or dictate discharge summaries in patients' charts based on the events in the patient's hospital stay if granted such authority by the medical staff with approval of the governing body. Authentication of the discharge summary will be completed by the attending physician or other responsible provider. Ultimately, the attending physician or other responsible provider is held responsible for the completion of the discharge summary.

Section 8. Release of Medical Information

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

All members of the medical staff and all other individuals governed by these Bylaws, Rules and Regulations are obligated to comply with and utilize the joint Notice of Privacy Practices adopted by the Board of Directors as the policy of Deaconess Hospital and as that policy may be amended.

Section 9. Possession and Removal of Records

All medical records are the physical property of Deaconess Hospital and shall not be taken from the confines of the hospital except in accordance with a court order, subpoena or statute. Unauthorized removal of a medical record from the hospital by a member of the medical staff is grounds for corrective action by the Medical Staff Executive Council.

In case of readmission of a patient to the hospital, all previous records shall be available for the use of the attending medical staff member. This provision shall apply whether the patient is being attended by the same medical staff member or by another.

Access to all medical records of all patients shall be afforded to medical staff members in good standing for a bona fide study and research consistent with preserving the confidentiality of personal information of the individual patient and the requirements of the HIPAA Privacy Rule and other state and federal laws and regulations governing research. All such projects shall be approved by the Medical Record Committee of the Medical Staff before records may be studied. Subject to the discretion of the Chief Executive Officer of the hospital, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering periods during which they attended such patients in the hospital.

Section 10. Filing of Medical Records

A medical record shall not be permanently filed until it is completed by the responsible member of the medical staff, except on order of the Medical Record Committee.

Section 11. Delinquent Medical Records

The medical staff member will have the responsibility of completing the Discharge Summary within 7 days and the remainder of the patient record within thirty (30) days following the date of discharge of the patient. Refer to Hospital Policy and Procedure No. 50-10, Medical Staff Delinquent Chart Procedure.

All medical records which are incomplete due to lack of a discharge summary 7 days following discharge of the patient and/or otherwise not completed or missing signatures within thirty (30) days after discharge of the patient shall be considered delinquent. It is the responsibility of the medical staff member to review and complete his/her records.

Section 12. Correcting An Error

Errors should be corrected by drawing a single line through the mistake. Date and sign (or initial) the correction. The date must reflect the date the correction was made and not the date of the original entry.

IV. ELECTRONIC CLINICAL INFORMATION SYSTEM

Section 1. General

Any member of the medical staff wishing to exercise admitting or clinical privileges and any allied health care provider wishing to exercise clinical privileges at the Hospitals (except Deaconess Women's Hospital) must be proficient in the Epic electronic clinical information system ("the Epic system") and must utilize the Epic system when providing health care within the Hospitals.

Section 2. Purpose

Each member of the medical staff and each allied health care provider as set forth above is required to learn and competently use the Epic system to assure that the clinical information in the Epic system is complete and accurate and that other members of the medical staff, other allied health care providers and Hospital personnel may rely upon the clinical information in the Epic system. Use of the Epic system is essential to the continuous quality improvement program of the Hospitals.

Section 3. Demonstrating Proficiency in the Epic System

The Hospitals will grant security access to the Epic system only to members of the medical staff and allied health care providers who have completed Epic training and demonstrated a competency rate of 80 percent or higher on the Epic examination. For medical staff members and allied health care providers who do not successfully complete the competency exam, additional training will be available to assure a reasonable opportunity to achieve sufficient competency levels. A minimum of twelve hours of Epic training will be required before a member or allied health care provider will be allowed to take the Epic exam.

Section 4. Failure to Comply

A member of the medical staff who is not in compliance with the Epic training and use provisions of this Rule after a reasonable opportunity to comply will not be eligible for reappointment and will be subject to automatic suspension of admitting and clinical privileges under Section VIII(D)(2) of the Medical Staff Bylaws. An allied health care provider who is not in compliance with the Epic training

and use provisions of this Rule after a reasonable opportunity to comply will not be eligible for reappointment and will be subject to automatic suspension of clinical privileges under Section V(E)(e) of the Medical Staff Bylaws.

V. PROCEDURES

Section 1. Sedation and Anesthesia

The medical staff acknowledges that human consciousness and responses to pain run a spectrum from the fully conscious and alert to general anesthesia. For the purposes of granting privileges to individual practitioners, the spectrum is divided into:

a) Minimal sedation (anxiolysis), meaning a drug-induced state in which patients respond normally to verbal commands. During minimal sedation, there is no impairment of ventilatory and cardiovascular functions.
b) Moderate sedation is defined as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.
c) Deep sedation is defined as a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to maintain independently ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate.
d) Anesthesia consists of general anesthesia and/or spinal or major regional anesthesia.

All physicians and allied health care providers who are licensed to administer or prescribe drugs sufficient to induce minimal sedation are granted privileges to do so without submitting special qualifications for those privileges. Special documentation of consent for minimal sedation is not required. Assessment of the patient's condition prior to initiation of minimal sedation is no more extensive than evaluation of the patient for the procedure to be performed.

The Credentials Committee in consultation with the Anesthesia Department will establish special qualifications to order or administer drugs for moderate sedation and privileges to do so will be granted only on individual application and qualification. Physicians will document separately or as part of the consent for the procedure to be performed the patient's condition, including but not limited to documentation of the patient's consent to undergo the risk of deeper sedation than intended. The patient's condition, including but not limited to documentation of vital signs, is to be documented immediately prior to use of moderate sedation. Individual practitioners other than CRNAs and physician anesthesiologists applying for deep sedation privileges must demonstrate competency the equivalent of those practitioners. Anesthesia privileges are available only to physician anesthesiologists and CRNAs.

Agents for moderate sedation include but are not limited to the following drugs given in appropriate dosages for moderate sedation:

a) Versed (Midazolam)
b) Valium (Diazepam)
e) Stadol (Butorphanol Tartrate)
f) Fentanyl Citrate

c) Demerol (Meperidine)
d) Morphine Sulfate
g) Nubain

In order to qualify for privileges in moderate sedation, a practitioner must view the moderate sedation video and achieve a passing score of at least 80% correct on the accompanying test.

Section 2. Autopsies

Every member of the medical staff shall be actively interested in the securing of autopsies whenever possible. No autopsy shall be performed without the written, witnessed telephonic or telegraphic consent of the responsible relative or person. The attending and any consulting physician(s) shall be notified whenever consent is given for an autopsy sufficiently in advance to allow the physician(s) to attend if desired. All autopsies shall be performed by one of the hospital's pathologists or by a physician who is appropriately delegated this responsibility. The criteria for securing an autopsy is as follows:

1. Deaths in which an autopsy may help identify unknown and unanticipated medical and/or surgical complications.
2. Deaths associated with obstetrical complications.
3. Deaths in which the cause is not known with certainty on clinical grounds.
4. Cases in which an autopsy may help allay concerns of the family regarding the death.
5. Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards.
6. Sudden unexpected or unexplained deaths which are apparently natural and not subject to the coroner's medical jurisdiction.
7. Neonatal and pediatric deaths in which the cause is not known with certainty on clinical grounds.
8. Deaths in which it is felt that an autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs.
9. Cases of exceptional academic interest which may contribute to the understanding of the disease process and advancement of medical science.

Section 3. Infection Control

Definite infections shall be reported on the appropriate infection reporting forms. Infections should be cultured, and sensitivity tests run to guide potential antibiotic therapy.

Section 4. Communicable Diseases

Refer to Hospital Policy and Procedure 50-31 and the Infection Control Manual, Chapter 400, Procedure 401.7 and 401.8. These procedures are to be complied with by the Medical Staff.

Section 5. Code Blue Response

The responsibility to respond to a "Code Blue" (cardiac arrest) is shared by every member of the medical staff present in the hospital at the time such an alert is called except as provided below. All available medical staff members (including the Hospitalists, Critical Care Specialists, and Emergency Physicians) should proceed to that area as soon as possible to render such emergent treatment as may be indicated. The attending physician for the patient will be immediately notified and will assume responsibility for

further care and disposition. It is understood that the primary area of the staff Emergency Physician's responsibility remains in the Emergency Department which will remain staffed with an Emergency Physician at all times.

VI. QUALITY IMPROVEMENT

Section 1. Core Care Teams

Members of the medical staff are encouraged and expected to participate in efforts to improve continuously the clinical outcomes and satisfaction of our patients. Participation on Core Care Teams is one of several opportunities to participate in continuous improvement of our processes.

Section 2. Medical Staff Quality Committee

The Medical Staff Quality Committee will serve as the primary multi-specialty peer review committee of the medical staff and will coordinate the quality improvement activities of the medical staff. This is a peer review committee with responsibility for evaluation of patient care rendered by professional health care providers as set forth in the Indiana peer review statutes and covered by the privileges and immunities contained in those laws. If a breach in quality and/or hospital safety procedures is found to have occurred, the Medical Staff Quality Committee may require a medical staff member to perform further CME, attend classes and/or impose a fine up to $1,000. If a serious breach of quality is suspected in an individual medical staff member, the Committee will forward a request for corrective action to the Medical Staff Executive Council.

Section 3. Incident/Occurrence Reporting

Any incident or occurrence reported by hospital personnel involving a physician or dentist on the medical staff or an allied health care provider with clinical privileges shall be electronically reported promptly upon discovery and reviewed by the Risk Management Department on behalf of the Medical Staff Quality Committee. An incident or occurrence is defined as an event that is inconsistent with the normal or expected operation of the hospital or routine care of a patient. An incident or occurrence report should be written whenever such an occurrence threatens or could threaten proper delivery of care to patients or the functioning of the hospital. The purpose of incident/occurrence reports is primarily corrective rather than punitive, but if correction is not promptly obtained, these reports may serve as evidence in a disciplinary action.

Objective: To deal fairly and professionally with questions involving members of the medical staff and allied health care providers.

Procedure: 1. Incident/Occurrence Forms may be initiated electronically via Midas + RDE by anyone whenever there is an occurrence or situation involving a physician/dentist/AHP that appears to warrant the awareness of the Medical Staff Quality Committee.
2. Completion of the form does not imply, per se, that there is any fault, blame or inappropriate action. As the title implies, incident/occurrence forms are simply meant

to cover "unusual situations" that are outside the norm of usual and customary day-to-day practice.

3. The Medical Staff Quality Committee or its delegate will:
    A. Review the form;
    B. Obtain additional information from appropriate individuals, if necessary;
    C. When appropriate, notify the physician/dentist/AHP involved of the report and allow for a response which should be entered into the electronic reporting system;
    D. Indicate action required, if any, on the form; and
    E. File the report in the secure electronic file.

4. The Medical Staff Quality Committee may delegate performance of any or all of these responsibilities to the Chief Medical Officer, the Safety and Risk Management Analyst or other staff members to the committee as appropriate.

VII. DEACONESS HEALTH SYSTEM CODE OF CONDUCT

The Deaconess Health System Code of Conduct is attached to these Rules and Regulations and incorporated herein.

CODE OF CONDUCT

Deaconess Health System

PURPOSE

- To optimize communication and interpersonal relations.
- To improve the care that is given to our patients.
- To reinforce an atmosphere of mutual respect for all who work or practice within the Deaconess Health System.
- To establish a process for reporting and addressing problematic behavior.
- To minimize liability of the Medical Staff, Hospitals, and their employees.
- To prevent conduct which:
    a) Interferes with an individual's ability to practice safely.
    b) Creates a hostile or intimidating work environment.
    c) Disrupts the delivery of patient care.

APPLICATION

This Code of Conduct applies to all Deaconess Health System employees (referred to as "staff"), members of the Medical Staff & Allied Health Staff (referred to as "physicians"), and House staff (referred to as "resident physicians").

STANDARDS OF BEHAVIOR

- Expected Behaviors
    a) Communication will take place in a timely fashion, involving the appropriate person(s), in an appropriate setting.

b) Communications, including spoken remarks, written documents, and emails, will be honest and direct and conducted in a professional, constructive, respectful, and efficient manner.
c) Telephone communications will be respectful and professional. Initiators will prepare for their call by gathering all necessary information, organizing their questions or comments, and coordinating with others who need to reach the same individual about other issues. Receivers will respond in a courteous and professional manner.
d) Cooperation and availability are expected of physicians, resident physicians, and staff on call. When individuals are paged, they will respond promptly and appropriately.
e) Be understanding that a variety of experience levels exists, and that tolerance for those who are learning is expected.
f) Compliance with Deaconess Health System policies and procedures.
g) Participation in auditing and feedback activities as part of performance improvement.

- Unacceptable Behaviors:
  a) Shouting or yelling.
  b) Use of profanity directed at another individual or healthcare professional.
  c) Slamming or throwing of objects in anger or disgust.
  d) Hostile, condemning, or demeaning communications.
  e) Offensive or derogatory comments.
  f) Sexual comments/innuendos.
  g) Racial, religious, or ethnic slurs.
  h) Criticism of performance and/or competency delivered in an inappropriate location (i.e., not in private) and not aimed at performance improvement.
  i) Other behavior demonstrating disrespect, intimidation, or disruption to the delivery of quality patient care.
  j) Retaliation against any person who addresses or reports unacceptable behavior.
  k) Unlawful discrimination or harassment based upon any legally protected characteristic, including race, color, religion, national origin, sex, sexual orientation, pregnancy, age, disability, or military status.
  l) Threats of violence.

MEETING FOR RESOLUTION

The optimal way to address inappropriate conduct is a face-to-face meeting between the parties involved using the following steps:

- The person who was aggrieved is expected to address the issue with the other party in a timely manner and private setting using this Code of Conduct as a reference.
- This meeting may be more productive after a “cooling off” period of a few hours or a few days so that the parties involved can gain perspective in the precipitating events and process breakdowns that may have been contributing factors.
- If facilitation of the discussion is needed, the department manager and appropriate physician leadership can serve as facilitators.
- Sincere apologies should be encouraged, and every reasonable attempt should be made to defuse the situation without further intervention.

- If clinical care/ hospital process deficiencies are discovered during this face-to-face meeting, these concerns need to be addressed by the department's leadership for improvement.
- No documentation of incidents resolved by the parties is required.

WRITTEN REPORT FOR UNRESOLVED ISSUES

- If the issue is not resolved after a reasonable attempt by the affected parties, the situation may be reported using the Remote Data Entry (RDE) system (see attached form). The completed form will be electronically sent to the Deaconess Health System Risk Management office, where all concerns will be logged.
- Concerns will be reviewed by the Risk Management Office. Concerns regarding a physician will be referred to the Medical Staff Quality Committee (MSQC) for review. Those regarding resident physicians will be forwarded to the residency Program Director. Each review will include viewpoints of all involved parties and possible clinical care/hospital process deficiencies that may have contributed to the situation.

ACTION FOR UNRESOLVED ISSUES

- If the complaint is found to have merit, the following action should be taken:
  a) For Deaconess Health System employees including physicians, their immediate supervisor and a representative from Human Resources will be sent a copy of the complaint and the review. They will develop a plan for appropriate counseling and intervention.
  b) For non-employed physicians, MSQC will handle the matter according to its normal procedure and/or forward a copy of the complaint and review to their department chief or medical director to develop a plan for appropriate counseling and intervention.

- For physician and non-physician employees of Deaconess Health System, any action reported in accordance with the Code of Conduct may be considered by Deaconess Health System to be a disciplinary action and will be treated in accordance with Deaconess Health System policies.
- For physicians, an "adverse action," as defined in the Medical Staff bylaws, will be taken only by the Medical Executive Council according to the procedures described in the bylaws and Fair Hearing Plan and is considered a peer review activity. Any necessary disciplinary action for resident physicians will be conducted pursuant to the Family Medicine Residency Manual.
- To protect privacy, written reports containing individual's names or departments will be kept confidential except to those deemed necessary for support and completion of the procedures outlined herein and will only be emailed using secure encryption and to the minimum number of recipients necessary.
- A summary of action taken will be sent to the Risk Management Office and logged with the original complaint.
- Semi-annual review of data trends will be conducted through the Risk Management Office and reported to the MEC, the hospital management and the Quality Committee of the Board of Directors.

Deaconess Health System

CODE OF CONDUCT
ACKNOWLEDGEMENT STATEMENT

I understand this Code of Conduct applies to all Deaconess Health System employees (referred to as "staff"), members of the Medical Staff & Allied Health Staff (referred to as "physicians"), and House staff (referred to as "resident physicians").

I UNDERSTAND THE PURPOSE IS

- To optimize communication and interpersonal relations.
- To improve the care that is given to our patients.
- To reinforce an atmosphere of mutual respect for all who work or practice within the Deaconess Health System.
- To establish a process for reporting and addressing problematic behavior.
- To minimize liability of the Medical Staff, Hospitals, and their employees.
- To prevent conduct which:
    a. Interferes with an individual's ability to practice safely.
    b. Creates a hostile or intimidating work environment.
    c. Disrupts the delivery of patient care.

I have read and agree to abide by the Deaconess Health System Code of Conduct.

_____ _____

Signature **Date**

_____ _____

Printed Name **Physician/Employee ID Number**

Adopted:	MEC	02/16/2021
	DHH Board of Directors	02/25/2021
Revised:	MEC	04/20/2021
	DHH Board of Directors	04/22/2021
Revised:	MEC	07/20/2021
	DHH Board of Directors	07/22/2021
Revised:	MEC	08/15/2023
	DHH Board of Directors	08/24/2023
Revised:	MEC	01/15/2025
	DHH Board of Directors	01/23/2025
Revised:	MEC	04/16/2025
	DHH Board of Directors	04/24/2025
Revised:	MEC	5/21/2025
	DHH Board of Directors	5/29/2025