# RULES AND REGULATIONS OF THE MEDICAL STAFF

## SECTION 1: STATEMENT

Medical Staff Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws shall be adopted in accordance with this Article. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

## SECTION 2: GENERAL

A. Acceptance of a member of the Medical staff of Deaconess Union County Hospital, in Morganfield, Kentucky, shall automatically constitute an agreement by that member to abide by the Rules and Regulations of the Medical Staff and be governed by the Corporate Bylaws of the Hospital.

B. Unprofessional and unethical conduct or violation of the Rules and Regulations of this staff shall constitute grounds for expulsion from the Hospital. Any member so charged shall have the opportunity of appearing before the Executive Committee of the Medical Staff in accordance with the procedures set forth in these Bylaws.

C. Physicians admitting private patients in this Hospital shall be responsible for giving information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient that is to be admitted.

D. The attending physician shall be held responsible for preparation of the complete medical record for each patient. This record shall include identification data, complaint, personal history, past history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or a discharge note and autopsy findings when available.

E. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsies shall be performed without the proper written consent. All autopsies shall be performed by the Hospital pathologist or by a physician delegated to this responsibility.

F. All non-private or medically indigent patients shall be attended by members of the Active staff and any patient who is admitted to the Hospital who has no attending physician shall be assigned to a member of the Active Staff on duty.

G. Members of the Medical Staff shall encourage consultations. In case of charity patients, any physician, osteopath or dentist shall give his/her services free. A consultant shall record his/her findings and recommendations, which shall form a part of the patient's record.

H. Each member of the Medical Staff, or his/her alternate, shall see all of his/her patients once a day and a daily, meaningful progress note will be written. However, the final progress note may be written at any time within 24 hours of discharge.

1. Only physicians can write orders with the following exceptions:
2. Physician Extenders -- as noted in Article V, Part C.
3. Medical Students, Nursing Students and Physician Assistant Students -- as noted in Article IX, Part D, Section 6:

## SECTION 3: HOSPITALIST:

A. Will respond to all "Code Blue" calls;

B. Will see all patients who present to the Emergency Room except in the event the physician has been contacted by the patient prior to arrival to the Emergency Room and the private physician contacts the Emergency Room advising of this arrangement;

C. Will admit all patients under a designated physician who will treat or be responsible for follow-up care.

D. When called by nursing staff, Hospitalists will respond and examine restrained patient within one (1) hour of attending physician order.

E. All Emergency Room Records are to be completed by the end of the ER physician's twelve (12) hour shift. ER Records not completed within seven (7) calendar days of their shift will be considered delinquent. Accumulation of five delinquent charts may be grounds for disciplinary action, including suspension of Medical Staff privileges.

F. Deaconess Union County Hospital Paramedics can perform pre-Hospital medical screening examination in consulting with the Emergency Room physicians.

G. IM injections may be given to patients presenting to the Emergency Room within six (6) hours of being seen by a physician.

H. The Hospitalist will sign off on all APRN notes and orders.

I. Physicians who work in ER on a part-time basis (as part of a contractual agreement) will not use their influence to attract patients to another facility when effective or appropriate care can be rendered at Deaconess Union County Hospital. (This is not to prohibit patients from using clinical judgment in evaluating the level of care required for a patient or to deter a patient's freedom of choice).

J. History and physical examinations may only be performed by physicians, physician assistants, podiatrists, and advanced registered nurse practitioners that hold current Hospital privileges or a physician who is licensed in the state of Kentucky and is a member in good standing on staff at a Joint Commission, or CMS or AOA approved Hospital.

K. A medical screening examination is defined as the process to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency exists.

L. An emergency screening exam shall be conducted on every patient who presents for emergency treatment, or for active labor by a physician, unless the Medical Staff authorizes other qualified medical personnel (i.e., R.N., L.P.N., Physician Assistant) through protocol, policy or procedure approved by the Medical Staff.

M. Consulting Staff Physicians may order treatment for their patients. In case of any problems the consulting physician will be notified.

N. In the case of an emergency medical condition, all physicians with Medical Staff privileges shall be qualified to stabilize a patient by utilizing their medical judgment, independent knowledge, and if necessary, through consultation with other Medical Staff members.

O. The following ER philosophy and protocols are approved by the Medical Staff:

1. ER Philosophy
2. Protocols
3. Scheduled Patient
4. Medical Screening Exam
5. Evaluation of Obstetrical Patients

## ER PHILOSOPHY

A. It is the policy of Deaconess Union County Hospital to accept and treat within its capabilities every patient, without regard to race, national origin, sex, religion, type of illness, physical or mental capabilities or ability to pay. Treatment shall not be delayed in order to obtain payer source information.

B. In no event shall a different level of care be provided to any patient based upon race, national origin, sex, religion, type of illness, physical or mental capabilities or ability to pay.

C. The Emergency Department is designed, equipped and staffed to provide prompt, courteous and competent treatment to every patient who presents to the Department. Medical and nursing personnel are on duty twenty-four (24) hours a day, with other professional services available immediately or within a reasonable period of time.

D. The purpose of the Emergency Department is:

1. To provide care of individuals with acute medical or surgical emergencies;
2. To provide personalized care in a manner that enables the patient and his/her significant others to view the Emergency Department experience as a positive interaction with the health care system. This is to be accomplished without compromising good standards of care while upholding the moral and ethical principles of care in emergency medicine;
3. To integrate fully with the other disciplines of the Hospital and with the surrounding community, including all aspects of disaster planning, and
4. To provide pre-Hospital care by serving as a base station for approved ambulance care units.

## ER SCHEDULED PATIENT

Certain out-patient procedures may be performed in the Emergency Department or shall gain entry to the Hospital through the Emergency Department without the patient being considered an emergency visit.

## SECTION 1: GENERAL INFORMATION:

A. Physicians having Medical Staff privileges at Deaconess Union County Hospital may schedule certain non-emergency out-patient procedures, examinations or evaluations with the Emergency Department, primarily as an entry point to the Hospital and for convenience of the patient.

B. The physician will either give a phone order for treatment to the Emergency Room nurse or the patient will present with a written order for all scheduled procedures, examinations or evaluations.

C. Scheduled cases are not considered an emergency and do not require the Emergency Room physician to see and perform a medical screening examination unless the patient presents with symptoms unrelated to the scheduled visit. If there is a question as to the condition of a patient, an appropriate medical screening exam shall be performed.

D. Emergency Room records are not used for scheduled cases. Examples of possible scheduled procedures are:

1. Patients who are to receive a physician ordered injection or an IV of less than one hour duration.
2. Persons presenting for Work Track rechecks.
3. Appointment with attending physician to be seen at the Hospital.

SECTION 2: PROCEDURE:

A. Patient is seen by the Emergency Room nurse and assigned to an available room.

B. The patient is registered by the Admission Clerk, using the appropriate patient type, service code, admitting type and source code.

C. The nurse will perform a nursing evaluation and record the patient's chief complaints, allergies and vital signs on the interdisciplinary progress note. All interventions by the Emergency Room nurse or the attending physician will also be recorded on the progress note.

D. If during the nurse evaluation, it is determined conditions exist which are in addition to those the patient presented for, the Emergency Room physician will see the patient and the attending physician will be notified without delay for approval or determination of payer source. The patient record should then be converted to a full Emergency Room record and logged as such.

E. Discharge instructions will be provided to the patient on release from the area.

F. Work track recheck patients will be given an appointment time to return when released after the initial visit.

G. The patient information is to be entered into the "Scheduled Out-Patient" log and **NOT** the Emergency Room log unless the procedure in paragraph 4 above is implemented.

## MEDICAL SCREENING EXAM:

Every person who requests emergency treatment shall have the right to receive an appropriate medical screening exam and treatment for their condition within the capabilities of Deaconess Union County Hospital including routinely available ancillary services and if necessary, available on-call physicians.

An emergency medical screening exam is a process, the details of which depend upon the individual circumstances and may consist of a history or physical or utilization of any routinely available ancillary tests and if necessary, available on-call physicians, necessary to reach the determination as to whether an emergency medical condition exists.

An emergency medical screening condition is defined as a medical condition manifesting itself by acute systems of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part or with respect to a pregnant woman who is having contractions

## PROCEDURE:

The emergency medical screen exam shall be conducted by a physician unless other medical personnel are qualified within the scope of their license to make an assessment of the patients as authorized by the Medical Staff through its Bylaws or Rules and Regulations.

Individuals shall initially see an Emergency Department Registered Nurse who shall triage and initiate a screening exam which shall consist of an assessment of the patient's condition within the scope of the Nurses license and training and further as authorized by any Medical Staff approved protocols. The screening exam shall be concluded by the Emergency Room physician utilizing such consultation with other physicians who specialize in clinical areas which are deemed necessary in his/her clinical judgment to determine whether an emergency medical condition exists.

## SECTION 3: ADMISSIONS

The Hospital shall admit patients suffering from all types of disease for which it is capable of providing care and further will render emergency treatment to the degree possible for those cases which it cannot provide ongoing care.

## SECTION 4: ORDERS

A. All verbal/telephone orders may be taken from any member of the Active, Associate, Courtesy or Consulting Medical Staff by the Hospital personnel as follows:

1. Nursing: RN or LPN
2. Cardiopulmonary Services: Respiratory Therapist
3. Radiology: Radiologist, Technician, Radiologist designee
4. Rehabilitative Services: Physical Therapist, Physical Therapist Assistant, Occupational Therapist, Occupational Therapist Assistant, Speech Language Pathologist
5. Pharmacy: Pharmacist
6. Dietary: Dietitian, Dietary Manager

7. Pathology: Pathologist, Pathologist Designee, Technician

B. Verbal orders given over the telephone shall be signed by the person to who dictated with the name of the physician per his/her or her own name. At his/her next visit, the attending physician shall sign such orders.

C. The Hospital personnel receiving the verbal/telephone order shall record in the medical record. Record the time, date, type order (p.o. or v.o.), physician's name, and the first initial and last name and title of the person taking the order.

D. Third party orders (i.e. - orders given by the physician to one person and then relayed to the authorized employee of the Hospital) are not restricted if the order involves the physician and two (2) authorized Hospital employees.

E. Standing orders shall be formulated either by the Full Medical Staff, Executive Committee, or the appropriate committees of the Medical Staff. They can be changed only by mutual consent of the Medical Staff or its committees. These orders shall be signed by the attending physician and shall become a permanent part of the patient's record.

F. A physician may obtain consent from a patient who has received a pre-anesthetic analgesic, sedative or anesthetic agent provided that immediately prior to signing the consent and after evaluation of the patient, the physician who is to perform the procedure documents in the patient's medical record the following:

1. The patient is oriented to time, place and person.
2. The risks, potential benefits and alternatives of the procedure have been explained to the patient by the physician and that the patient indicates he/she understands.
3. In the physician's opinion, the patient is mentally capable of comprehending everything explained in (2) above.
4. If this is not documented in the medical record, patients who have received sedation must wait a minimum of three hours before signing an operative consent for an elective procedure.

G. Automatic stop orders apply to:

1. Parenteral Class II narcotics after seven days unless a specific period of time is designated in the order that initiated the administration of the drug.

H. When a patient is transferred to a different level of care, the physician giving the transfer order is to review and either approve or delete all previous orders.

I. All orders pertaining to a patient moved to Surgical Services shall be canceled upon arrival in Surgical Services. Post-procedurally, a physician may re-institute the previous orders or write new orders.

## SECTION 5: RECORDS

A. The complete history any physical examination shall be performed on all patients within 24 hours after admission and shall be recorded or dictated not later than 24 hours after admission. Except in a case of emergency, all patients for surgery shall have the history and physical examination performed and either recorded or dictated prior to the time stated for the operation. In those cases

in which the history and physical examination has been dictated but is not present on the patient's chart, the attending physician must record in his progress notes all pertinent information deemed necessary for the welfare of the patient. If the history and physical has not been recorded, any elective surgical procedure shall be canceled unless the attending surgeon states in writing that such a delay would constitute a hazard to the patient. The only exception to performing complete history and physical examinations within 24 hours of hospital admission, is as follows:

B. When a complete history and physical examination has been performed within 30 days of admission, a durable, legible copy of this report may be used in the patient's hospital medical record provided it is updated with the patient's current condition within 24 hours of admission or prior to surgery or a procedure requiring anesthesia services, and the history and physical if from a physician on staff at the hospital.

C. All records are the property of the hospital. Records shall not leave the hospital without a court order, subpoena or statute.

D. In case of readmission, all previous records shall be available for the use of the attending physician. This shall apply whether this patient is a private or charity patient and whether he is attended by the same physician or by another physician.

E. Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bona fide study and research consistent with preserving the confidentiality of the personal information concerning the individual patients.

F. Surgical operations shall be performed only with the consent of the patient or his legal representative, except in a case of extreme emergency.

G. All operations performed shall be fully described by the operating surgeon and recorded on the patient's chart.

H. A medical record will be considered delinquent 30 days after discharge. (EXCEPTION: The medical record must be completed in its entirety within 15 days following the patient discharge from a licensed psychiatric unit - STATE LAW.)

I. Should the physician fail to complete these delinquent records, he/she agrees that his her emergency and elective admitting privileges shall be voluntarily relinquished on that date (Monday), by issuing a written notice to the Medical Staff Secretary. If the written notice has not be received by the Medical Staff Secretary by 10:00 a.m. on the following Wednesday, is/her admitting privileges will be automatically suspended. The physician so suspended shall be notified, in writing, by the Secretary of the Medical Staff. Any physician so suspended shall not admit any new patients under his/her own name or in another physician's name. The physician so suspended, however, shall remain responsible for providing care for those patients who are presently under his/her care either as the attending physician or as a consultant.

J. When his/her charts are completed to the satisfaction of the Director of Medical Records, and the Medical Staff Secretary has been notified, in writing, that he/she has voluntarily relinquished his/her admitting privileges, the physician may apply in writing to the Chief of Staff with a copy to the hospital's Executive Director to regain his/her admitting privileges. Temporary privileges

may be granted to the physician as provided in Article IX, Part F, Section 1, of the Bylaws while the request is being processed in the proper fashion.

K. All physicians' entries into a patient's medical record shall be authenticated with the written signature or electronic signature on the original document by the physician making the entry, with the exception of verbal orders by partners/associates, provided an agreement has been signed and is on file in the Medical Records Department. The use of stamp signatures is not acceptable. The entries shall include:

1. H & P
2. Progress Notes
3. Discharge Summary
4. Consultation Report
5. Operative Procedure Report
6. Informed Consents

L. The patient shall be discharged from the hospital only upon a physician order of a member of the Medical Staff. The discharge summary will be performed within thirty (30) days after discharge. For this reason, the chart will be placed in the physician lounge the next scheduled date to work after discharge. If the chart is removed for any reason before the discharge summary is completed, notice of removal, location of chart and remaining time for completion shall be given to the physician the next scheduled work day.

M. The Director of Medical Records shall provide a monthly report of the professional work of the hospital for the previous month which shows patients discharged, the results, deaths, causes of death, autopsies, consultations and infections.

## SECTION 6: DIAGNOSTIC FACILITIES

A. A laboratory shall be provided in the Hospital to insure as complete a service as possible. The Hospital pathologist shall be responsible for all work required to be performed in the laboratory and for all reports on this work. He/she shall be available to the operating room department whenever an immediate diagnosis is required to guide a surgeon in his/her operating.

B. Diagnostic x-ray facilities shall be provided within the Hospital to insure as complete an x-ray diagnostic service as possible. All work shall be performed under the direction of a qualified radiologist. All x-ray reports are to be fully recorded and signed by the radiologist. All patients shall receive prompt service, that all requests shall be completed and returned not later than 24 hours after their receipt.

C. If a physician is not scheduled to work again within 30 days of a patient discharge the physician will be responsible for forwarding contact information with medical records to get access to the electronic record so that it can be completed.

## SECTION 7: CONSULTATION AND TISSUE EXAMINATION

A. Consultation by qualified physicians who are members of the Medical Staff are required on the following surgical procedures prior to surgery:

   1. Uterine curettage or other procedures, by which a known or suspected pregnancy may be interrupted,

   2. All cases in which, according to the judgment of the physician, the patient is not a good risk for surgery or in which the diagnosis is obscure.

B. All tissues removed by operations shall be sent to the Hospital pathologist who shall make such examination that he/she may consider necessary to arrive at a diagnosis. His/her report is to be fully recorded and signed and made a part of the patient's chart.

## SECTION 8: MISCELLANEOUS

A. Drugs to be administered to the patient in the Hospital should meet the standards of the United States Pharmacopoeia, National Formulary, new and non-official remedies, with the exception of drugs for bona fide and clinical investigation with specified drugs that the Hospital pharmacy cannot provide.

B. The Hospital may maintain a Medical Library, located at Methodist Hospital, Henderson, KY.

C. Particular rules and regulations may be adopted, amended, repeated or added by vote of the Executive Committee and/or full Medical Staff at any regular or special meeting provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee and/or full Medical Staff 14 days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee and /or full Medical Staff before the change is voted upon. Changes in the rules and regulations shall become effective only when approved by the Board.

## SECTION 9: MEDICAL STAFF QUALITY

DEFINITION:

A. Focused Professional Practice Review (FPPE): The process whereby the organization evaluated the privilege-specific competence of the practitioner

   1. When a practitioner does not have documented evidence of competently performing the requested privilege at the organization.

      a. ALL newly appointed practitioners

      b. ALL existing practitioners who have been granted NEW privileges.

   2. When a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

B. Ongoing Professional Practice Review (OPPE): Periodic performance review (at least every 6 -9 months) of all current staff utilizing established performance indicators. Allows the organization

to identify individual professional practice trends that impact on quality of care and patient safety.

AUTHORITY AND RESPONSIBILITY:

The Medical Staff and Board of Directors of hospital have the authority and responsibility to monitor and evaluate the quality of patient care through organizational and Medical Staff quality improvement activities. The Medical Staff has a leadership role in organizational improvement activities designed to ensure that the findings of the assessment process are relevant to an individual's performance. The Medical Staff is responsible for determining the use of information in the ongoing and focused professional practice evaluation process of an individual granted clinical privileges. The Case Management Committee will monitor the overall quality process.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE):

NEW PRIVILEGES: A PERIOD OF FOCUSED REVIEW WILL BE CONDUCTED FOR:

- ALL newly appointed practitioners
- ALL existing practitioners who have been granted NEW privileges. The FPPE plan will be practitioner specific. It should include the general elements described for OPPE as well as any specialty specific privileges that he/she has been granted.

A. The FPPE plan will be practitioner specific. It should include the general elements described for OPPE as well as any specialty specific privileges that he/she has been granted.

B. One or more of the following elements will be utilized for each privilege:

    1. Outcomes
    2. Complications
    3. Readmissions
    4. Quality of documentation
    5. Returns to the Operating Room

C. Methods for evaluation may include

    1. Chart Review
    2. Direct observation
    3. Statistical Review
    4. Proctoring

D. Observation Time Period: will be for the first 3 months and/or until 5 procedures have been evaluated. If fewer than 5 procedures or less than 6 admissions have occurred during the 3 months the observation period will be extended.

E. Final Decision: The results of any negative evaluations will be immediately conveyed to the practitioner.

F. If there is insufficient activity to fulfill the requirements of FPPE, it will be considered that the practitioner has voluntarily relinquished his privilege(s).

PROBLEM PRIVILEGES:

A. FPPE will be initiated, upon recommendation of the Executive Medical Staff in the following circumstances:

1. By important single events
2. By absolute levels, trends, or patterns that significantly and undesirably vary from established patterns of clinical practice, recognized standards or from that of other peers.
3. Significant staff or patient complaint
4. When the results of an organizational improvement activity or Medical Staff monitoring function identify a significant deviation from accepted standards of practice.
5. Adverse or negative performance trend over 6 consecutive months of OPPE.
6. Repeated failure to follow hospital or Medical Staff policy (e.g. late to surgery, failure to respond to pages, refusing to allow read-back, etc.)
7. When the Medical Staff wishes to exceed expected standards or performance. Specific measure and indicators used to assess, measure and evaluate individual performance is outlined in the organization's Performance Improvement Plan.

B. The Case Management Committee will consider the following issues a "trigger" to begin the process of considering conducting a focused evaluation (these events may not necessarily result in a focused evaluation):

1. Incident Report on a physician
2. Outlier report at the Case Management committee
3. Notice from regulatory agency
4. Informal oral report from staff

FPPE will be initiated if the Medical Staff Executive Committee feels that the circumstances suggest the possibility of a threat to patient safety or well-being. The need for the FPPE will be conveyed to the practitioner by the chief of staff or his designee in writing.

C. When FPPE (for Problem privileges) has been initiated:

1. Method of establishing a monitoring plan:
   a. The plan for focused evaluation will be developed by the Case Management Committee consisting of 3 physicians
   b. Final approval of the plan must be given by the medical executive committee

2. The elements of the plan will vary according to circumstance, but will be both retrospective and prospective:
3. In the case of an interventional or surgical procedure:
    a. Review of all available records for the prior six months specific to the procedure
    b. Monitoring of all similar procedures prospectively to include indications, direct monitoring during the procedure, and concurrent monitoring following the procedure.

D. In the case of a more general competency
    a. Review of all admissions for the preceding 3 months
    b. Concurrent review of all admissions/consultations performed by the practitioner from the start of FPPE

E. Reviews will be conducted in-house unless it is determined that an outside evaluation is required. The Review period should not exceed 15 days.

F. At the completion of the review, a determination will be made concerning continuation of privileges or request for corrective action. The recommendation will be made to the Medical Executive Committee. If a serious threat to patient welfare is discovered, the corrective action process should immediately be initiated.

G. The decision to assign a period of performance monitoring is based on the practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege-other existing privileges in good standing should not be affected by this decision.

## ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE):

A. The Medical Staff will conduct periodic performance review of all current Medical staff and Allied Health Professional Staff utilizing performance indicators established in this plan and specialty-specific indicators established in the Rules and Regulations. Specific special medical privilege criteria will be utilized as applicable. OPPE allows the organization to identify individual professional practice trends that impact on quality of care and patient safety and is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal.

B. The information used in the OPPE may be acquired through one of the following:
    1. Periodic chart review
    2. Direct observation
    3. Monitoring of diagnostic and treatment techniques
    4. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at Surgery, nursing and administrative personnel
        a. Relevant information obtained from the OPPE is integrated into PI activities while preserving confidentiality.

b. If there is uncertainty regarding the practitioner's performance, the organized medical staff should follow the course of action defined in the Medical Staff Bylaws for further evaluation of the practitioner.

C. The process for OPPE includes the following:

1. A clearly defined process that facilitates the evaluation of each practitioner's professional practice defined above.
2. The type of data to be collected is determined by the Medical Staff Executive Committee. Joint Commission regulations list the following elements, which should be reviewed:

D. CLINICAL PERFORMANCE

1. Medical assessment and treatment of patients
2. Adverse privileging decisions
3. Use of medications
4. Use of blood and blood components
5. Operative and other procedures
   a. Appropriates (judgement)
   b. Outcomes (clinical and technical skills
6. Appropriateness of clinical practice patterns
7. Utilization Review: Appropriate LOS, Denials
8. Significant departures from established patterns of clinical practice
9. Department Specific indicators
10. Meeting the criteria for autopsies
11. Sentinel Event Data
12. Patient Safety Data i.e. use of do not use abbreviations.

E. CITIZENSHIP:

1. Accurate, timely, and legible completion of medical records (quality of H&P's, op notes, etc.)
2. Participation in education of patients and families.
3. Coordination of care, treatment and services with other practitioners and hospital personnel.
4. Patient satisfaction survey results

F. May also include:

1. Requests for tests and procedures

2. Morbidity and mortality data
3. Use of consultants
4. Other relevant criteria as determined by the Medical Staff
5. Return to the OR
6. Return to the ER
7. Surgical site wound infections
8. Critical events
9. Core Measure compliance

G. Information resulting from the OPPE is used to determine whether to continue, limit or revoke any existing privileges or initiate a problem specific focused review.

H. The timeframe of data collection must be defined and the method of collecting date defined:

1. Retrospective review
2. Concurrent Review

I. Once the indicators are established and methodology developed for collection of the data then the task of analysis must occur.

1. Data analysis: Conversion of all raw numbers to rate-based performance.
2. Incumbent on having good denominator data (sufficient numbers)

J. Once the rate-based data is collected on an individual basis, it must be compared to "peer" or departmental performance utilizing industry-accepted standards.

K. If no activity during the review period(s), OPPE from hospital(s) where the practitioner has activity will be used at the time of reappointment.

## EXTERNAL REVIEW:

A. Circumstances under which monitoring by an external source is required:

B. The Case Management Committee cannot make a determination and requests external review.

C. The individual whose performance is under review requests external peer review.

D. The Medical Staff Executive Committee requests external review.

E. Competition among the service or department members.

F. Lack of sufficient expertise to review.

G. External Review will be done through the Medical Director at Methodist Hospital, Henderson, KY.

# SECTION 10: PEER REVIEW POLICIES

DEFINITION:

Peer Review is defined as the evaluation of an individual MD/DO, and other Licensed Independent Practitioner's (LIP) professional performance.

PURPOSE:

To ensure the Medical Staff of Deaconess Union County Hospital assesses the professional performance of Licensed Independent Practitioners who have been granted clinical privileges utilizing the information for the purpose of improving patient care.

GOALS:

A. Seek to improve quality of care rendered by individual LIP's.

B. Identify areas in which performance improvement can be enhanced.

C. Monitor LIP's clinical privileges.

D. Analyze data in a fashion which can demonstrate trends

POLICY:

A. All Peer review material shall be considered privileged and confidential and in accordance with Hospital & Medical Staff By-Laws; State & Federal Laws and regulations pertaining to confidentiality and non-discoverability.

B. Provider specific information will be provided to an involved LIP in any situation which in the opinion of the Executive Committee the information should be provided.

C. Provider specific information will be utilized in credentialing and re-credentialing processes, and as appropriate in performance improvement activities.

D. All provider specific and performance improvement information which concerns an LIP will be kept in a safe, locked file. This information shall include:

   1. Utilization Review and Performance Improvement data.

   2. Sentinel Events

   3. Significant incidents and near misses.

   4. LIP specific correspondence regarding any performance improvement, credentialing, or re-credentialing information.

E. All peer review information shall be available only to authorized individuals who may have a legitimate need to know the information based upon their respective responsibilities either as Medical Staff Leaders or Hospital Employees, with the access to information limited to the extent necessary to carry out their assigned responsibilities. Authorized individuals are as follows:

   1. Medical Staff Officers, Committee Chairmen as relevant

2. Medical Director
3. Hospital Risk Manager
4. Hospital Director of Case Management
5. Medical Staff Secretaries and members of the Case Management to the extent which this information is necessary for re-credentialing processes.
6. Accrediting Body surveyors (State Licensure, Joint Commission)
7. Individuals with legitimate purposes as determined by the Hospital Board of Directors or its Legal Counsel.

F. No copies of peer review documents will be created nor distributed unless authorized by Hospital management or Hospital policy.

## CIRCUMSTANCES REQUIRING PEER REVIEW:

Peer Review will be performed in the following circumstances:

A. Re-credentialing
B. Deaths
C. Adverse outcomes
D. Sentinel Events where applicable
E. Monitors/studies, when Physician is outlier

Peer Review shall be conducted by peers who have been granted privileges equal to or more than the practitioner in question. In the case of an M.D. or D.O., a peer is another person who is licensed as an M.D. or D.O. A peer of a licensed independent practitioner (LIP) is a practitioner who is licensed the same as the LIP.

Peer Review on Physician Assistants may be conducted as determined by the Medical Staff and the institution as these individuals are employees of, and under the direct supervision of the Medical Staff Members.

In general Peer Review is conducted by the following Committees:

A. Medical Staff Committee
B. Executive Committee
C. Case Management Committee
D. Surgery Case Review / Transfusion Committee
E. Pharmacy/Therapeutics
F. Credentials Committee
G. Infection Control Committee

In any case where the possibility of a pre-determined bias or in the event of a conflict of interest, the membership of any of the above committees may be altered by appointment and/or removal of any member by the Chief of Staff. The change in Committee membership shall be only for the specific purposes of performing peer review on the specific LIP in question. In the final consideration the MSEC will consider minority opinions as well as the opinion of the LIP under review.

In special/specific circumstances a Peer Review panel may be appointed by the Executive Committee. This appointed Committee will act under the direction of the Executive Committee. Upon the completion of the investigation and filing of a report with the Executive Committee, the appointed Committee will disband.

All peer review activities are to be performed in a reasonable time frame. In those situations in which a Medical Staff members privileges are to be modified by reduction or terminated the Peer Review will be performed as specified in the Medical Staff By-Laws as denoted in the re-credentialing process.

In those cases determined to be a Near Miss or Sentinel Event, the immediate review will be performed within 72 hours of identification of the event. In case of a sentinel event, review and action will be determined following completion of a root-cause analysis. The responsibility for the review; rests with the clinical Medical Staff department in which the event occurred; the Executive Committee; and the Board of Directors.

### CIRCUMSTANCES REQUIRING EXTERNAL PEER REVIEW:

An external Peer Review Panel may be requested when one of the following conditions exists:

A. When there are an insufficient number of Medical Staff peers to perform a review.

B. The internal peer review panel is unable to reach a conclusion on the matter/s pending.

C. In any situation in which a majority of the internal review committee members feel they lack the expertise to perform the review.

An individual who is under surveillance or discussion by a Peer Review Panel shall have an opportunity to meet with the Panel for purposes of answering questions from the panel; providing explanations of findings; and for purposes of answering questions from the panel; providing explanations of findings; and for discussing the facts with Panel as is necessary.

## SECTION 11: PHYSICIAN HEALTH

Deaconess Union County Hospital and its Medical Staff will have available educational programs which address prevention of physical, psychiatric or emotional illness of individual members of the Medical Staff, and foster confidential diagnosis, treatment and rehabilitation of those individual members who may suffer from potentially impairing condition(s).

<u>The process for insuring the above conditions are attained shall include:</u>

A. Education of the Medical Hospital staffs about illness and impairment recognition issues specific to physicians.

B. Self-referral by a physician or referral by Hospital staff.

C. Referral to appropriate sources for diagnosis and treatment of the condition.

D. Except as limited by law, ethics, or when patient safety is threatened, confidentiality of the physician shall be maintained.

## SECTION 12: CODE OF CONDUCT:

The MODEL MEDICAL STAFF CODE OF CONDUCT as copyrighted by the American Medical Association is hereby adopted as the standard of conduct for members of the Medical Staff. Each member of the Medical Staff shall sign an acknowledgment indicating they have read and agree to conduct themselves in accordance with the standards as set forth therein.

The procedure for complaints set forth in the AMA MODEL MEDICAL STAFF CODE OF CONDUCT shall not apply. Instead, the following procedure shall be followed to address any complaint of violation of this Article X, Part F: Ethics/Code of Conduct

### INITIAL MEETING:

A. If the parties involved are members of the Medical Staff, they are encouraged to conduct a face to face meeting in a productive professional environment with the goal of reaching an amicable resolution. During the face to face meeting, the parties shall:

1. Use this Code of Conduct as a reference.
2. If needed, use Medical Staff leadership to help facilitate the discussion.
3. If clinical care and/or process deficiencies have been identified during this meeting, those will be forwarded to the appropriate Medical Staff department for consideration.

B. If the parties involved include non-Medical Staff members, the recommended face to face meeting will also include the director of the affected Hospital employee's department.

### UNRESOLVED ISSUES:

If the complaint of violation of this Article X, Part F. Ethics/Code of Conduct, is not resolved using the process in paragraph 1 of this Article, the Medical Staff member, Hospital employee or Hospital department director shall file a written report which will be sent to the Medical Staff office. The Medical Staff office will distribute this report to the Chief of Staff, the Chairman of the appropriate committee of the Medical Staff involved and the appropriate committee of the Medical Staff. Additionally, a copy shall be sent to the Executive Director of Deaconess Union County Hospital.

### GROUNDS FOR ACTION:

In the event the process set forth in paragraph 1 and 2 above fail to result in an acceptable resolution, the matter will be considered Grounds for Action and the process set forth in Article XI, Part C, herein shall be followed.

## SECTION 13: AMENDMENTS

Particular rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee and/or Full Medical Staff at any regular or special meeting provided that copies of the

proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee and/or Full Staff 14 days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee and/or Full Staff before the change is voted upon. Changes in the rules and regulations shall become effective only when approved by the Board.

## SECTION 14: MEDICAL FUTILITY IN END OF LIFE CARE

When further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider=s perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what futility, in the particular instance. This may interrupt satisfactory decision-making and adversely affect patient care, family satisfaction and physician-clinical team functions.

To assist in fair and satisfactory decision-making about what constitutes futile intervention, the following seven steps should be included in such a due process approach to declaring futility in specific cases.

A. Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy and physician on what constitutes futile care for the patient and what falls within acceptable limits for the physician, family and possibly also the institution.

B. Joint decision making should occur between patient or proxy and physician to the maximum extent possible.

C. Attempts should be made to negotiate disagreements if they arise and to reach resolution within all parties' acceptable limits with the assistance of consultants as appropriate.

D. Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable.

E. If the institutional review supports the patient=s position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged.

F. If the process supports the physician=s position and the patient/proxy remains unpersuaded, transfer to another institution may be sought; and, if done, should be supported by the transferring and receiving institution.

G. If transfer is not possible, the intervention need not be offered.

## SECTION 15. SURGICAL RULES AND REGULATIONS

The Surgical Rules and Regulations are hereby made an official part of the Rules and Regulations of the Medical Staff Bylaws.

## SECTION 16. MEDICAL STAFF APPOINTMENT, RE-APPOINTMENTS AND CLINICAL PRIVILEGES

The following items will be required to be submitted for Initial Medical Staff appointment:

- Copy of Driver's License
- Photo (JPEG) this will be attached to your delineation of privileges as an identifier.
- Copy of all Certificates and Diplomas (i.e. Board Certificates, ACLS, BLS, Moderate Sedation, etc.)
- Copy of social security card
- Copy of COI,
- Authorization to be listed as a certificate holder on COI.
- Copy of DEA
- Copy of Medical License
- Copy of immunization record
- Criminal Background Check
- Excluded Provider Registry
- Release
- Health Status Questionnaire
- Alternate Designee

The following items will be required to be submitted for Medical Staff Reappointment:

- Copy of Driver's License
- Release
- Health Status Questionnaire
- Alternate Designee

# RULES AND REGULATIONS FOR PROCEDURES PERFORMED IN SURGICAL SERVICES

Surgical Services is defined as a department of Deaconess Union County Hospital, composed of offices, lounges, storage rooms and operating rooms located on the North Wing of the Hospital, accessible from the main corridor and the adjacent to the Emergency Department, accessible through the Emergency Department. The operating rooms are utilized for the performance of the following procedures. The operating rooms are utilized for the performance of the following procedures:

- Pre-Admission Testing
- Admission of Out-Patients for Preoperative Preparations
- Endoscopy
- Major Surgery
- Minor Surgery
- Pathology
- Post-Anesthesia Recovery
- Step-down Recovery

Equipment and supplies for performing diagnostic procedures and peri-operative nursing for all patients experiencing surgical intervention/diagnostic procedures.

Any physician who is granted privileges to perform procedures in Surgical Services must be either board certified or have completed an approved residency in a surgical field recognized by the Accreditation Council of Graduate Medical Education of the American Medical Association, or by the American Dental Association, or by the American Podiatric Association with the following exceptions:

A. An internist or medical sub-specialist may use an operating room for the purposes of performing those procedures which he/she has been granted privileges to perform in this institution.

B. A general/family practice physician may use an operating room for the purpose of performing those procedures which he/she has been granted privileges to perform in this institution.

C. A general dentist may use an operating room for the purpose of performing those general dental procedures which he/she has been granted privileges to perform in this institution.

All patients who undergo surgery or other invasive procedures which require general, spinal, regional block anesthesia, that in the manner used, may result in the loss of the patient's protective reflexes shall be rendered services in accordance with these policies. For the purposes of these policies, invasive procedures include, but are not limited to, percutaneous aspirations, biopsies and endoscopic examinations.

The terms operating surgeon and physician as used in these policies shall be synonymous.

## SECTION 1: GENERAL MAJOR ANESTHESIA CASES

This section shall apply to patients experiencing surgical intervention within Surgical Services who are to receive regional, spinal, or general anesthesia and specifically to those patients who are to receive sedation/medication which the attending physician will be unable to administer.

A. SCHEDULING:

1. ELECTIVE PROCEDURES:

a. Elective cases will be scheduled on first-come, first serve basis.

b. It is the responsibility of the operating surgeon to provide an assistant in any case in which an assistant is necessary, irrespective of whether the case may have begun as a diagnostic or therapeutic procedure. An M.D. assistant is not mandatory but at the physician's discretion.

c. The operating surgeon must be in the Surgical Services Department before the patient's anesthesia is begun, irrespective of the time of day. Further, in those cases where an Operating Surgeon has determined an assistant is necessary, the assistant must be physically present in the Hospital before the anesthesia is begun.

2. EMERGENCY PROCEDURES:

Emergencies will:

a. Be scheduled at the discretion of the operating surgeon

b. Interrupt the daily surgical schedule if the operating surgeon attending the emergency patient determines the interruption to be necessary.

c. Be performed in the first available operating room, if urgent.

d. Non-urgent emergencies may be performed at the completion of regularly scheduled cases, or later in the day; however, they should be scheduled allowing sufficient time to complete the procedures by 7:00 p.m.

B. ADMISSIONS:

All patients, irrespective of admission status or procedures to be performed, must be admitted allowing sufficient time, as determined by Surgical Services/Nursing Services, for their preoperative preparation, prior to the scheduled time of the procedure.

All patients, other than in-patients, should be "pre-admitted," in order that the physician can evaluate the necessary preoperative studies prior to the day of admission.

C. CHART REQUIREMENTS:

1. ELECTIVE PROCEDURES:

The following requirements must be met in a reasonable amount of time before the scheduled procedure:

a. A consent for the procedure/s signed by the patient or his/her legal representative.

b. A recording of the history and pertinent physical findings or a progress note entry stating the following information about the patient:

i. A history and pertinent physical has been dictated

ii. Surgical Diagnosis

iii. Known or suspected allergies

iv. General condition

v. Surgical risks

vi. Intent and/or expected benefit of proposed procedure.

2. EMERGENCY PROCEDURES:

Chart requirements for emergency procedures are the same as for elective procedures; however, in extreme emergencies, the case may proceed when the chart requirements have not been met, provided that prior to the patient being taken to Surgical Services, the operating surgeon enters on the progress note the following information.

a. The chart requirements that have been deleted, and

b. Any delay to meet the chart requirements would be detrimental to the patient's well-being.

D. ANESTHESIA:

1. All anesthesia administered in the Surgical Services area will be in accordance with the Medical Staff approved Policies and Procedures.

2. All patients identified in the general policy statement will be monitored by the Department of Anesthesia. Anesthesia personnel will be responsible for the administration of all drugs and/or anesthetic agents administered in Surgical Services, other than agents being used as either IV analgesics or local anesthetics which may be administered by the operating surgeon.

E. SPECIMENS:

All specimens, including any/all foreign bodies, will be sent to the Pathology Laboratory, except as provided in the "Specimen Deletion Policy" of the Surgical Services Master Policy and Procedure Manual.

F. "TO FOLLOW" CASES:

1. Only approximate times can be given for "to follow" cases.

2. Surgical Services will notify the operating surgeon when the patient is to receive the pre-medication in "to follow" cases. The surgeon must indicate that he/she will be available to perform the procedure at the indicated time.

3. In a case which does not require a pre-medication, Surgical Services will contact the operating surgeon approximately fifteen (15) minutes prior to the anticipated time that the procedure will begin.

4. When the operating surgeon is notified by Surgical Services of the proposed time for the anticipated procedure to begin, and the operating surgeon indicates that he/she will be unavailable and cannot be available within fifteen (15) minutes of the anticipated time, the case will be canceled. Should sufficient time be available at the end of the regular operating schedule, the case may be "added on" at the end of that day's schedule.
5. In the event a regularly scheduled case is canceled, an attempt will be made to move the first "to follow" case to the canceled case's place. Should there be difficulty in moving the first "to follow" case into the place of the canceled, the list of "to follow" cases will be exhausted before another previously unscheduled case can be scheduled as a replacement.

G. OPERATING SURGEON'S RESPONSIBILITY:

The operating surgeon is responsible for:

1. Observing all policies relating to:
    a. Sterile technique
    b. Wearing appropriate apparel
    c. Infection control practices
2. Any other policy of Surgical Services which is relevant to the physician.
3. Writing or dictating an operative report immediately following the procedure.
4. Entering a brief operative note in the progress notes of the patient's chart, stating at least:
    a. Preoperative diagnosis
    b. Post-operative diagnosis
    c. Operative procedure
    d. Estimated blood loss
    e. Assistant's Name
    f. Condition of the patient on leaving the Operating Room
    g. Operating surgeon's name.

## MEDICAL STUDENTS, INTERNS AND RESIDENTS:

A. A medical student in a non-formal rotation may enter the Surgical Services operating rooms in the capacity as an observer if he/she is invited by the operating surgeon. He/she may not participate in the surgery.

B. A medical student in a formal rotation, who has completed a medical school rotation in surgery, and who is knowledgeable in sterile technique to the satisfaction of the Surgical Services Supervisor, and who is covered by surgical liability insurance by his/her training institution, may scrub and act as an assistant in surgery for cases which do not require an M.D. assistant, or in the role of a second assistant.

C. An intern or resident in a formal training program may perform in Surgical Services as stipulated in Article IX, Part D, Section 4, of the Medical Staff Bylaws, Rules and Regulations.

D. Interns and residents in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in the training protocols developed by the Executive Committee.

## SECTION 2: LOCAL IV/ANALGESIC CASES

This section applies to patient who receive either local anesthesia, or to patients who receive IV sedation/analgesic/medication.

A. SCHEDULING:

Scheduling will be the same as stated above in Section I, Item A, of these Rules and Regulations.

B. ADMISSION:

The patient's admission may occur on the date of the procedure, as long as sufficient time is allowed to properly prepare the patient before the scheduled time of the procedure.

C. CHART REQUIREMENTS:

1. A consent form for the procedure must be signed by the patient or his/her legal representative.
2. Relevant history and physical findings will be recorded by the operating surgeon.
3. The recording of a procedure note following the procedure.

D. PATIENT MONITORING:

All patients identified in this Section (II) of these Rules and Regulations will be monitored by a registered nurse employed in Surgical Services.

E. PROCEDURE FOR REGISTERED NURSE MONITORING:

1. Blood pressure, pulse, and respiration will be taken and recorded on admission to the Operating Room and every fifteen (15) minutes thereafter, until the procedure is completed.
2. Oximetry:
    a. The monitor lead will be applied to earlobe/index finger.
    b. Unit calibration will be verified.
    c. Digital readings will be recorded at 15 minute intervals.
    d. The physician/operating surgeon will be informed verbally if digital oxygen saturation readings reach a level of less than 90%, or the systolic blood pressure reaches a level of less than 100 or greater than 180.
3. Oxygen will be administered to the patient as ordered by the operating surgeon.
4. IV fluids will be started if ordered by the physician/operating surgeon.

F. IV MEDICATIONS:

Intravenous medications will be administered by either an M.D., or a member of the Department of Anesthesia or by a Surgical Services Registered Nurse.

The Executive Committee shall have the power to adopt such amendments to the rules and regulations as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the Executive Director and posted on the Medical Staff bulletin board for fourteen (14) days.

## ADOPTIONS OF RULES AND REGULATIONS

These Rules and Regulations of the Medical Staff are adopted and made effective upon approval of the Board superseding and replacing any and all previous Medical Staff Rules and to the requirements of these Bylaws.

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