Medical Staff Rules and Regulations
Jennie Stuart Medical Center

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INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee and the medical staff and approved by the Governing Board. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

ARTICLE II ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short-term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital or placed in outpatient observation services only by an appointee to the Medical Staff with admitting privileges.
b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted or placed in outpatient observation until a provisional diagnosis or valid reason for admission has been entered into the medical record. In case of emergency, such statement will be recorded as soon as possible.
c. **Admission Procedure:** Admissions and Observation placements must be processed through the hospital's admission coordinator. Beds will be assigned based upon:

    - The medical condition of the patient,
    - Satisfaction of medical appropriateness factors for patient status and level of care requested, and
    - The availability of necessary hospital staff, facilities, and services.

    It is the responsibility of the attending physician or his designee to ascertain through the admission coordinator whether there is an available bed with the necessary staff and services available.

2.1.2 Admission Priority

Prioritization of hospitalizations is as follows.

a. **Emergency Admission:** Emergency admissions are the most seriously ill patients whose condition is one of immediate and extreme risk. Such patients require immediate attention and would likely expire without stabilization and treatment. Emergency admissions or observation placements must be evaluated through the Emergency Department for initial medical assessment and stabilization services.
Emergency Admissions are a top priority.

b. **Urgent Admissions:** These cases meet the criteria for inpatient admission or placement into outpatient observation; however, their condition is not life-threatening. Urgent admission/observation patients will be placed into a bed as soon as one is available.

c. Elective Admissions: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area.

2.2 EMERGENCY DEPARTMENT MEDICAL SCREEN

All patients presenting to the Emergency Department will receive a medical screening examination by the Emergency Department physician, by a physician assistant under the supervision of an Emergency Department physician, or by an Emergency Department nurse practitioner acting under a collaborative practice agreement with an Emergency Department physician. Women over 20 weeks gestation who present with pregnancy related complaints may receive a medical screening examination by an obstetrical registered nurse who has been designated by the Governing Board based on demonstrated competence in the medical screening of patients with pregnancy related complaints.

2.3 EMERGENCY PATIENTS

A. Emergency Department coverage will be provided through equitable rotation among available providers within each specialty, or through hospital-administered arrangements. No specific number of call days is mandated in these Rules and Regulations. Coverage expectations may be defined by department agreements or determined administratively to ensure EMTALA compliance. The Medical Executive Committee (MEC) shall advise the Hospital on the specialties needed to ensure appropriate emergency coverage. The MEC, in conjunction with Hospital Administration, will review coverage adequacy regularly and may revise policies to ensure patient safety and regulatory compliance. The Medical Staff and Hospital Administration acknowledge that certain specialties may not provide 24/7 coverage. In such cases, care may be deferred to the next business day when clinically appropriate or transferred in accordance with EMTALA-compliant protocols. All gaps in coverage and call exemptions will be reviewed and approved by the MEC.

B. Members of the Medical Staff will be responsible for providing emergency and non-emergency medical services to his or her own patients in the emergency department unless coverage is arranged with another member of the Medical Staff with clinical privileges and abilities similar to those of the member being covered. The Medical Staff acknowledges that it is unreasonable to expect (sub) specialists without sufficient colleagues with similar privileges to be available on all their non-call days.

   If a member of the Medical Staff has not made arrangements for coverage with an appropriate medical staff member and is unavailable or unreachable by the emergency department, medical services will be rendered by the physician on the Emergency Department call schedule that has similar privileges until the unavailable medical staff member can assume care. If no member on Emergency Room call has similar privileges, arrangements can be made for patient transfer.

   Repeated failure to arrange for coverage when unreachable or unavailable resulting in the emergency assumption of care by another medical staff member may result in MSQR and MEC review for correction, which may result in the restriction or revocation of hospital privileges.

C. Members of the medical staff will be responsible for providing emergency and non-emergency medical services to patients in the Emergency Department when he/she is on the Emergency Department/Unassigned Patient call schedule.

   The critical safety net provided by the Emergency Department/unassigned patient call schedule necessitates that the on-call medical staff member or their covering provider be available to the Emergency Department at all times. Changes to the Emergency

Department/Unassigned patient call schedule must be communicated to the Emergency Department and the Medical Staff Coordinator.

If the Emergency Department/Unassigned Patient on call provider is unreachable or unavailable, the department chair, medical staff president or administrator on-call should be contacted by the Emergency Department to assist in identification of an appropriate medical staff member willing to provide emergency medical treatment until the on-call medical staff member can assume care.

Unavailability when on call may result in MSQR and MEC review for corrective action, which may result in loss of hospital privileges.

D. When the emergency department notifies a physician, he/she will be expected to respond verbally within a reasonable amount of time after he/she is notified. The requirement of this Rule may be satisfied by the member arranging coverage by another member of the medical staff, provided, that the member furnishing coverage has clinical privileges and abilities similar to those of the member being covered and provided that the coverage furnished by the replacement individual will not result in unreasonable risk of harm to patients in the Emergency Department, Emergency Department coverage includes, but may not be limited to, those expectations set by Federal EMTALA guidelines, in so far as to aid in necessary stabilization, acute treatment, and outpatient follow up.

E. A physician accepting responsibility of coverage for another physician will assume that physician's emergency call as well as other duties unless stipulated. The emergency call list will be prepared and distributed from the Medical Staff Office. Days of availability are to be provided to the Medical Staff Office no later than the 25th of each month. If there is more than one physician in the same specialty, it is their responsibility to coordinate the days to ensure appropriate coverage. The Medical Staff Coordinator will communicate with the Chairman of each department in the event that days overlap in coverage. The Chairman of their respective department shall have the authority to assign days if needed. If the Chief of each service is not available, the President of the Medical Staff will assign appropriate scheduling.

F. If there is a change in the Emergency Department/Unassigned Patient coverage after initial distribution of the schedule, the medical staff office is to be notified of the change[s]. The emergency room and answering service will be notified.

G. Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should

be used in developing departmental policies regarding unassigned emergency call obligations:

i. Unassigned call duties, to supply basic stabilization and disposition of the patient, should be based on the appointee's clinical core privileges even though specific items in the core may be deleted. Physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category; the MEC, in conjunction with the CEO, shall determine which specialties are required to have call schedules.

ii. Unassigned call duties shall be assigned by the Department Chair and approved by the MEC and Governing Body for those specialties in which coverage is not available 24/7/365.

iii. Military physicians from Fort Campbell shall not serve on the ED call roster unless they are working in a capacity outside of their military duty and are fully credentialed and privileged with appropriate professional liability insurance.

iv. Unassigned duties may be divided by department, specialty, or subspecialty.

v. Physicians on unassigned call may take call at more than one hospital simultaneously, as long as they have back-up coverage, with appropriate notification to the emergency department, in case of emergencies occurring simultaneously at two different hospitals.

vi. Physicians may perform elective surgery while on unassigned call, as long as they have back-up coverage in case of emergencies that occur while performing elective procedures.

vii. Physicians may serve in a community call plan, in accordance with EMTALA guidelines, for the provision of call in a specialty.

viii. The ED practitioner must make the first call regarding an unassigned patient to the physician on the unassigned call list when an emergency medical condition exists. The emergency department physician must speak to the on-call physician if there is potential for patient transfer.

ix. An impairment which is alleged to limit an appointee's ability to provide Unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

H. Incidents that fall outside the expected response time can be sent to Quality Management for review. If concerns remain after initial inquiries by Quality Management [trends], then the cases[s] will be referred to the Medical Staff Quality Review Committee for further management.

I. Members of the Medical Staff responsible for providing emergency medical services in the emergency department must respond within a reasonable time if the on-site emergency physician requests a personal response or comes to the hospital. If it is agreed between the on-site emergency physician and the on-call physician that the patient will be seen in the on-call physician's office the next day, *or at a time agreed to as appropriate,* the on-call physician will see the patient in his/her office for one visit without regard to the patient's ability to pay for that specific visit.

Inpatient Management

A. Patients are to be under the care of a physician as defined by Centers for Medicare/Medicaid Services A-0017 482.12 [c] [1]. Members of the medical staff are responsible for providing coverage for his/her patients while in the hospital. Physicians are to respond within a reasonable amount of time when notified. In the event of physician unavailability this requirement may be satisfied by the responsible physician arranging coverage by another medical staff member with clinical privileges and abilities similar to those of the physician he/she is covering for, provided that the coverage by the covering physician will not result in unreasonable risk of harm to patients while in the hospital.

B. Members of the Medical Staff will be responsible for providing emergency and non-emergency medical services to inpatients if needed for a consultation when he/she is on the Emergency Department/Unassigned Patient call schedule. When the hospital staff notifies a physician, he/she will be expected to respond within a reasonable amount of time after he/she is notified. The requirement of this rule may be satisfied by the member arranging coverage by another member of the Medical Staff, provided that the member furnishing coverage has clinical privileges and abilities similar to those of the member being covered and that the coverage furnished by the covering physician will not result in unreasonable risk of harm to hospital inpatients.

C. Incidents that fall outside the expected response time can be sent to Quality Management for review. If concerns remain after initial inquiries by Quality Management trends, then the cases[s] will be referred to the Medical Staff Quality Review Committee for further management.

2.4 TRANSFERS

2.4.1 Transfers From Other Acute Care Facilities

In coming acute transfers to the hospital must be processed through the admissions coordinator. Transfers coming from a higher level of care will be considered on a case by case basis.

Consideration may be given to those cases in which the patient no longer requires a higher level of care, but continues to meet the criteria for continued short term acute care hospitalization.

Otherwise, transfers from other acute care facilities must meet the following criteria:

a. The patient must be medically stable for transfer.
b. The patient's condition must meet medical necessity criteria for inpatient admission or placement in outpatient observation.
c. The patient must require, and the Hospital must be able to provide, a higher level of care and/or a specific inpatient service not available at the transferring facility.
d. Responsibility for the patient must be accepted by:
    - an attending physician with admitting privileges at this hospital who has completed a medical peer discussion with the transferring physician, and
    - the hospital representative who is duly authorized to administratively accept the patient in transfer.

2.4.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. The attending practitioner will be notified of all transfers.

2.4.3. Transfers To Another Hospital

Emergency Department patients who are transferred to another hospital must follow the Hospital policy on transfers to ensure EMTALA compliance. Inpatients who are transferred to another hospital must follow the Hospital policy on transfers.

2.5 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others.

2.6 PROMPT ASSESSMENT

New admissions must be personally examined and evaluated by the attending physician or his/her designated covering physician within 24 hours. Patients admitted to an intensive care unit must be seen within 8 hours; unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness. Patients admitted to the Adult Behavioral Health Unit may be personally examined and evaluated by the psychiatric attending physician in person or via telehealth and a member of the Medical Staff with admitting privileges and with privileges in Internal Medicine or Family Practice.

2.7 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

a. A list of all medications the patient is to take post-discharge;
b. Dietary instructions and modifications;
c. Medical equipment and supplies;
d. Instructions for pain management;
e. Any restrictions or modification of activity;
f. Follow up appointments and continuing care instructions;
g. Referrals and orders to the next indicated level of care and/or services; and
h. Recommended lifestyle changes, such as smoking cessation.

2.8 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. If possible, the attending physician shall be notified before the patient has left against medical advice.

2.9 DISCHARGE PLANNING

Discharge planning is a formalized interdisciplinary process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners will participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

ARTICLE III MEDICAL RECORDS

3.1 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means. A printed transcribed report does not require authentication; transcribed reports are

electronically authenticated. Use of stamps is not allowed. (reference Medicare Manual- Chapter 3, Section 3.3.2.4)

3.2 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately.

The clarity, completeness, and legibility of medical record documentation may be considered in evaluating the practitioner at the time of reappointment. Practitioners whose medical record entries are habitually unclear, incomplete, or illegible may be subject to corrective actions as determined by the Medical Executive Committee.

3.3 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Standard Abbreviations: Only standard symbols and abbreviations will be used. To be considered "standard," the symbol or abbreviation must be listed in the most recent edition of "Medical Acronyms, Eponyms & Abbreviations". If a non-standard symbol or abbreviation is used, its full meaning must be explained on the same page.

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

- U for Units
- IU for International Units
- QD for Daily
- QOD for Every Other Day
- Trailing Zero (X.0)
- Lack of Leading Zero for Numbers Less than Zero (.X)
- MS or MSO4 for Morphine Sulfate
- MGSO4 for Magnesium Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses, consents and procedures in the medical record.

3.4 CORRECTION OF ERRORS

Medical records should not be improperly altered. When it is necessary to correct an error in the medical record these guidelines should be followed:

a. A single line should be drawn through the erroneous entry; under no circumstances should the original entry be obscured.
b. The corrected entry must be authenticated with the practitioner's signature and the date and time. (It is noted that these guidelines only apply to the paper record, and not to the electronic record.)

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination report must include the following information:

a. Chief complaint or reason for the admission or procedure;
b. A description of the present illness;
c. Past medical history, including current medications and allergies and may include past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
d. An age-appropriate social history;
e. A pertinent family history;

f. A review of systems;

g. Relevant physical findings;

h. Documentation of medical decision-making which may include a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

For the Behavioral Health Unit the history and physical examination shall also include information on the patient's alertness, debilities, emotional behavior, and a screening neurological examination which includes a cranial nerve examination.

A focused history and physical examination report or "outpatient assessment", used for outpatient procedures that do not require general anesthesia or deep sedation, should include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, and current diagnoses;

d. A review of systems relative to the procedure planned;

e. Relevant physical findings, including an evaluation of the cardiac and respiratory systems and the affected body system;

f. Documentation of medical decision-making which may include a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Attending Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the attending physician or his/her designee.

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Radiology Department (myelograms, abdominal and intrathoracic biopsy or aspiration), and

c. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, trans esophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).

3.7 PROGRESS NOTES

The attending physician, or his/her designee,(including an APRN or PA with appropriate clinical privileges) will record a progress note each calendar day, and at the time of each patient encounter on all hospitalized patients, excluding the day of admission and the day of discharge if the patient has been seen within the past day. Progress notes must document the reason for continued hospitalization. The attending physician must personally evaluate the patient at the time of admission (or within 24 hours and at least once during the course of the hospitalization. On days when the attending physician does not personally see the patient, a privileged APRN or PA designated by the attending physician may conduct daily rounds and document the patient's progress. The attending physician remains responsible for the overall plan of care and must be available for consultation. Rounding on patients via telemedicine will be acceptable but approved only on a provider case-by-case basis, not to exceed a period of three months. This can be extended with further approval from the MEC.

Different requirements apply to the Adult Behavioral Health Unit and to attending patients admitted to the Adult Behavioral Health Unit:

a. The attending physician [Psychiatrist] or APRN for the Unit will see and record a progress note on each patient admitted to the Adult Behavioral Health Unit every calendar day.
b. The attending physician [Psychiatrist] will personally round a minimum of one [1] time a week in person or via telehealth.

3.8 OPERATIVE REPORTS

A full operative report must be written or dictated immediately following surgery and signed by the surgeon. The operative report includes the following information: The name and hospital identification number of the patient; date and times of the surgery; name[s] of the licensed practitioner [s] who performed the procedure and his or her assistant [s] and a description of their tasks; The name of the procedure performed; A description of the procedure; the type of anesthesia administered; Findings of the procedure; complications (if any); Any estimated blood loss: Any specimen[s] removed; any prosthetic devices, transplants, grafts, or tissues implant; and The pre-operative and postoperative diagnosis.
[CMS 482.51(b)(6) and TJC RC.02.01.03 EP6]

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the

medical record before the patient is transferred to the next level of care. This progress note includes the name[s] of the primary surgeon[s] and his or her assistant[s] procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. [TJC RC.02.01.03 EP7]

3.9 CONSULTATION REPORTS

The Consultation Report should be completed and placed on the patient's chart within 24 hours. If dictated, a short summary of consultation shall be entered into the medical record at the time of completion of the consultation.

3.10 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the attending physician at the time of discharge, transfer, or death of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record. Once the pending diagnostic information has been received and a definitive diagnosis has been made, the practitioner will be required to document the diagnostic findings and final diagnosis in the patient's medical record.

3.11 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries will be authenticated by the discharging physician or his/her physician designee.

a. **Content**: A clinical summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the attending physician and will contain:
    1. Reason for hospitalization;
    2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
    3. Condition of the patient at discharge;
    4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
    5. Final diagnoses.

b. **Short-term Stays**: A discharge summary is not required for observation hospital stays of less than 48 hours, uncomplicated vaginal deliveries, uncomplicated inpatient only surgeries with stay less than two midnights, and normal newborn infant, provided the

discharging physician enters a final progress note that includes the condition of the patient at discharge and instructions given to the patient and family including medications, referrals and follow- up appointments.

c. **Timing**: A Discharge Summary must be entered in the medical record within fourteen (14) days of discharge, transfer, or death. Any transfer to another acute care setting or Skilled Nursing Facility, will require the discharge summary to be complete before transfer, as the facility will not accept the patient.

d. **Deaths**: A clinical summary is required on all patients receiving inpatient or observation services that have expired and will include the reason for admission, a summary of the hospital course and the final diagnosis.

3.12 ADVANCED PRACTICE PROFESSIONALS (APRN and PA)

The attending or supervising physician will review and cosign any history and physical examination completed by an Advance Practice Professional for inpatient or observation patients within one (1) day. The cosignature requirement applies only to H&Ps performed in the inpatient or observation setting. A history and physical examination performed and documented by an APRN or PA with appropriate clinical privileges in a provider-based clinic or other outpatient setting constitutes a complete H&P for purposes of satisfying pre-procedure and pre-surgery documentation requirements under CMS Conditions of Participation and the Medical Staff Bylaws (part 1, Section 2.6.8) and does not re2uire a physician cosignature. The attending or supervising physician's signature on progress notes signifies that the attending or supervising physician has reviewed the patient's medical record and approved the care rendered by the Advanced Practice Professional; cosignature on progress notes of APPs are not required. An admission order of an APP must be cosigned by a physician before discharge of the patient. The attending or supervising physician will countersign any discharge summary completed by an Advanced Practice Professional within thirty (30) days of discharge.

3.13 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any health care provider providing treatment to the patient without specific written authorization as permitted under the HIPAA Privacy Rule's Permitted Uses and Disclosures or by the appropriate Hospital authority in an emergency.

With respect to the electronic medical record system, access will be granted to any licensed Health Care Provider (or an approved designee) without specific written authorization as permitted under the HIPAA Privacy Rule's Permitted Uses and Disclosures clause only if the following conditions are met:

- The provider is providing treatment for the patient;
- The provider agrees to comply with the terms of the Hospital's relevant policies and confidentiality agreements; and
- The provider executes all agreements required for access.

Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records**: In case of readmission of a patient, all previous records will be made available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized removal or electronic transfer of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of an Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.14 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

3.14.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record in the timeframe noted in the Bylaws, Part I, Section 2.6.8.

b. A Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure. When the H&P examination is completed within 30 days before admission or registration, an updated exam of the patient including changes in condition will be documented prior to surgery or a procedure requiring anesthesia services.

c. An Operative Report must be entered in the medical record by the performing practitioner immediately following the surgery or procedure. If the Operative Report is not immediately available, then an Operative Note must be done prior to transfer to the next level of care (before transfer from PACU to the floor, or before the surgeon leaves the patient's bedside if they accompany the patient from the OR to the ICU;

d. An Inpatient Progress Note must be recorded and authenticated by the attending physician or designated covering practitioner at the time of each encounter, and on a daily basis ;

e. An Emergency Department Record must be completed by the responsible practitioner within 24 hours of the encounter;

f. A Consultation Note must be completed by the consulting physician within 24 hours of the consult request;

g. An authenticated/signed Discharge Summary must be entered in the medical record by the discharging physician or his/her designee within 14 days of patient's discharge, transfer or death following any inpatient stay or an observation stay greater than two midnights. [exception: see 3.11 b – short term stays]

h. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary.

i. All verbal orders must be signed within thirty (30) days after patient discharge by the ordering practitioner or another practitioner involved in the patient's care

j. Clinic visits in provider-based clinics must be completed within three (3) calendar days.

3.14.2 Suspension of Clinical Privileges for Incomplete Records

A weekly letter will be submitted listing all chart[s] determined as incomplete. Three letters will be utilized. The first letter is a friendly reminder, the second letter is a documented notification and the third letter allows the physician one last opportunity to complete his/her charts by the following Monday at noon.

The records remaining incomplete thirty days after discharge will be considered delinquent, and the physician may be suspended by the CEO until the chart[s] have been completed. After the chart[s] has been completed, the staff member will be automatically returned to the staff in his/her previous capacity. If, however, the physician has been suspended for greater than 60 days,

privileges are lost and the Staff member must reapply for membership and privileges on the Medical Staff as if he/she were applying for the first time. Suspension shall mean that the physician shall have no admitting or surgery privileges (including obstetrical procedures) in non-emergency situations. The physician will be responsible for any on call duties during this time. Exceptions to this rule can be made by the CEO in extenuating circumstances.

3.15 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

ARTICLE IV STANDARDS OF PRACTICE

4.1 ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The attending physician, or designee, will be responsible for:

a. The admission history and physical examination and

b. Daily rounds personally or through a designated APRN or PA with appropriate clinical privileges, documenting the patient's course of medical treatment, excluding the day of admission and the day of discharge if the patient has been seen within the past day. The attending physician must personally evaluate the patient at admission (or within 24 hours and at least once during the hospitalization and remains responsible for the overall plan of care.

4.1.2 Transferring Admitting Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff appointee, a note covering the transfer of responsibility will be entered on the order sheet of the medical record by the attending physician.

4.1.3 Critical Care Medicine – Intensive Care Unit

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.

All patients admitted to ICU status, regardless of admitting diagnosis or attending physician specialty, will be placed on an ICU admission worklist by the ICU nurse at the time of admission. The Pulmonary/Critical Care Medicine physician on duty will review the worklist and evaluate new ICU admissions during his or her next rounding period to determine whether Critical Care involvement is clinically indicated.

If the Critical Care physician determines that involvement is appropriate, the Critical Care physician will self-initiate a consultation autonomously and promptly notify the admitting or attending physician directly to collaborate on the patient's care.

If the Critical Care physician determines that Critical Care involvement is not medically indicated, the Critical Care physician or ICU nurse will document in the patient's medical record that the admission was reviewed and that the critical Care Physician determined involvement was not clinically indicated at that time.

The Critical Care physician retains the autonomy and authority to involve him/herself in the care of any ICU status patient, at any time, at his or her clinical discretion. This authority includes, but is not limited to, ordering diagnostic test, initiation or modifying treatment plans and writing orders as clinically indicated. Nothing in this section relieves the attending physician of his or her ultimate responsibility for the patient's care as described in Section 4.1.1.

4.2 ORDERS

4.2.1 General Principles

a. All orders for treatment will be in writing or electronically submitted.

b. Orders must be clear and unambiguous.

c. All orders must be specifically given by a practitioner who is privileged by the Medical Staff.

d. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.

e. Instructions should be written out in plain English. Prohibited abbreviations may not be used.

f. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible signature, date, and time.

4.2.2 Verbal Orders

Verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy.

b. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal orders, like written orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal orders must be signed by the ordering practitioner or another practitioner involved in the patient's care within thirty (30) days after discharge.

e. Orders may not be given verbally for cancer chemotherapy.

4.2.3 Electronic Orders

The Medical Executive Committee shall develop and maintain policies regarding the use of electronic orders and computerized order entry consistent with federal and state law.

4.2.4 Reconciliation of Medication Orders Following Surgery or Transfer

All previous medication orders must be reconciled when the patient is admitted from the Emergency Room, for surgery, or readmitted from another hospital or healthcare facility, and transferred from ICU to a lower level of hospital care, within a reasonable timeframe. Instructions to "resume previous orders" will not be accepted.

4.2.5 Drugs and Medications

The Hospital policy on ordering of medications shall be followed by all practitioners.

4.2.6 "Stat" Orders

"Stat" or "now" orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. "Stat" and "now" orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of "stat" and "now" orders may be grounds for corrective action.

4.3 CONSULTATION

a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges. The practitioner requesting the consult shall call the consulting practitioner directly and provide written authorization requesting the consultation to permit the consulting practitioner to attend or examine his/her patient.

b. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to his/her manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.4 DEATH IN HOSPITAL

4.4.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by the attending practitioner or his/her designee within a reasonable time. The attending practitioner's designee must be permitted by law to determine and pronounce death. A Registered Nurse may make the determination and pronouncement of death of a patient whose circulation and respiration are not being artificially maintained. The attending physician or his/her physician designee is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.4.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.5 AUTOPSY

It is the duty of the admitting physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico-legal or educational interest. The hospital policy "Autopsy & Coroner Notification" shall be followed.

4.6 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.6.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, including Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. Advanced Practice Professionals are not eligible for Medical Staff membership and may provide patient care only under the supervision of a physician who is an appointee to the Medical Staff.

4.6.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician is responsible for managing the health care of patients in all settings.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision must be within the scope of each practitioner's authorized practice, as defined by state law.

c. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The physician is responsible for the supervision of the Advanced Practice Professional in all settings.

e. The physician must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means.

f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician and the clinical privileges granted by the Hospital.

g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

h. The supervising physician is responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.

i. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and one or more alternate supervising physician.

4.6.3. Supervising Practice Agreements

Each physician assistant must have on file in the Medical Staff Services Office a written Supervision Agreement, if applicable, that describes all health care-related tasks which may be performed by the Physician Assistant.

4.6.4. Supervising Physician

The supervising physician must be available by telephone within thirty (30) minutes and must be able to respond on-site in a reasonable amount of time. A physician may not supervise more APPs than allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of an Advanced Practice Professional or other dependent health care professional may be subject to corrective actions as determined by the Medical Executive Committee.

4.6.5. Medical Record Documentation

Advanced Practice Professionals [APRN & PA] may enter history and physical examination, progress notes, consultation reports, discharge summaries and enter orders within the scope of their privileges as noted in Section 3.12.

4.6.6. Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement;
b. prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented in the Supervision Agreement;
c. provide a medical service that exceeds his/her clinical privileges granted by the hospital; and
d. exercise any privilege that exceeds those of the collaborating/supervising physician.

4.6.7 Advanced Practice Registered Nurses (APRNs) – Independent Practice Authority

Notwithstanding the general supervision requirements for Advance Practice Professionals set forth in Sections 4.6.1 through 4.6.6 Advance Practice Registered Nurses (APRNs) - including Certified Registered Nurse Anesthetist (CRNAs), Nurse Practitioners (NPs), Certified Nurse Midwives (CNSs) and Clinical Nurse Specialists (CNSs) – who have been granted clinical privileges at this Hospital are authorized to practice independently and are not required to have a supervising or collaborative physician as a condition of their privileges.

This provision is consistent with the Commonwealth of Kentucky's recognition of APRNs as licensed independent practitioners under KRS 314.011(8) and KRS 314.042, the Kentu7cky Board of Nursing's legal opinion that no statues required physician supervision of APRNs, and Kentucky's opt-out from the CMS federal physician supervision requirement for CRNAs (effective April 2012) APRNs shall exercise independent judgment within the areas of their professional competence consistent with their clinical privileges and applicable state law, Quality oversight of APRNs practice shall be maintained through the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes established by the Medical Staff.

Specifically APRNs with appropriate clinical privileges at this Hospital.

a. Are not required to have a supervising or collaborating physician on the Medical Staff.
b. Are not required to maintain a written Supervision Agreement or Collaborative Practice Agreement as a condition of privileges.
c. May provide services within their scope of practice and clinical privileges without physician supervision, direction, or immediate availability of a physician.
d. May independently order and administer medications, including controlled substances, as authorized by their clinical privileges and consistent with Kentucky law; and
e. Are not subject to the automatic suspension provisions related to loss of a supervising or collaborating physician.

APRNs remain subject to all other applicable provisions of these Rules and Regulations, including credentialing, privileging, peer review, FPPE, OPPE, medical record documentation requirements, and standards of professional conduct. APRNs must maintain any Collaborative Agreements for Prescriptive Authority (CAPA-NS and/or CAPA-CS) required under KRS 314.042 as a condition of their prescriptive authority; however, these state prescriptive authority agreements do not constitute a physician supervision requirement for purposes of clinical practice at this Hospital. Sections 4.6.1 through 4.6.6 shall continue to apply to Physician Assistants. In the event of any conflict between Section 4.6.7 and Sections 4.6.1 through 4.5.6, this section shall control with respect to APRNs.

4.7 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties.

4.8 CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines provide a means to improve quality and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and

patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The Medical Executive Committee may adopt evidenced-based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

ARTICLE V PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO NOT RESUSCITATE ORDERS {DNR}

The Hospital policy "End of Life Resuscitation Options" delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy "Adverse Events" delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS

The Hospital policy on restraints delineates the responsibilities, procedure, and documentation that must occur when ordering restraints.

5.7 ADVANCE DIRECTIVES

The Hospital policy on advance directives delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Requests to perform investigational studies and clinical trials will be authorized by the Compliance Department and Administration. After authorization, investigational studies and clinical trials conducted at the Hospital must be approved in advance by an Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI SURGICAL CARE

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and

anesthesia. The practitioner responsible for ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

6.4 TISSUE SPECIMENS

Specimens removed during an operation will be sent to the Hospital pathologist in accordance with the hospital policy "Specimens".

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID wrist band with the patient's name and date of birth. The Hospital policy on 'Universal Protocol' shall be followed.

ARTICLE VII RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The medical staff policy "Code of Conduct" shall be followed.

7.2 REPORTING IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the medical staff policy "Impaired Practitioner'.

7.3 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Jennie Stuart policy on Viewing of Medical Records regarding access to medical records of themselves or family members.

7.4 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on TB testing, influenza vaccination, and any testing/vaccinations as noted in policy.

7.5 COMMUNICATION

All practitioners must maintain a current accessible e-mail address on file in the Medical Staff Services Department.

All practitioners must supply the Medical Staff Services Department a current cell phone number.

All practitioners must use the accepted method of communication determined by the MEC.

ARTICLE VII ORGANIZATION AND FUNCTIONS OF THE MEDICAL STAFF

8.1 Organization of the Medical Staff

The medical staff shall be organized into five [5] departments: Medicine, Psychiatric Medicine, Surgery, Women -Maternal and Child Health, and Hospital-based Services. A department chair shall head each clinical department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

Medicine:	Family Practice, Emergency Medicine, Hospitalist, Internal Medicine and its subspecialties
Psychiatric Medicine	Psychiatry, Psychology
Surgery:	Surgery, Surgical subspecialities and Anesthesiology
Women/ Maternal & Child Health:	Obstetrics and Pediatrics
Diagnostic/Radiologic Services:	Pathology, Radiology, and Radiation Oncology

8.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, department chairs, hospital and medical staff committee chairs are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

8.3 Description of Medical Staff Functions

The Medical Staff, acting as a whole or through committee, participates in or has oversight over the following activities.

8.3.1 Governance, direction, coordination, and action:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members or APPs when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body;

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff, APPs, and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

8.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

- Medical assessment and treatment of patients
- Use of medications

- Use of blood and blood components
- Operative and other procedures
- Education of patients and families
- Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examinations
- Appropriateness of clinical practice patterns
- Significant departures from established pattern of clinical performance
- Use of developed criteria for autopsies
- Sentinel event data
- Patient safety data
- Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
- Findings of the assessment process relevant to individual performance

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

8.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the medical staff's and administration's approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis;

d. Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

8.3.4 Credentials review (see Credentials Procedures)

8.3.5 Information Management

a. Review and evaluate medical records to determine that they:

- Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken;. Document the promptness, pertinence, adequacy and completeness for discharged patients;
- Include documentation of hospital acquired infections and unfavorable reactions to drug and anesthesia;
- Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein.

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

8.3.6 Emergency Preparedness: Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

8.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources;

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members and APPs.

8.3.8 Bylaws review

a. Conduct periodic review of the medical staff bylaw, rules, regulations and policies;

b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

8.3.9 Nominating

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure;

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

8.3.10 Infection Control Oversight

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection.

b. Develop and approve policies describing the type and scope of surveillance activities including:

- Review of cumulative microbiology recurrence and sensitivity reports;
- Review of prevalence and incidence studies, as appropriate;
- Collection of additional data as needed;

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader;

h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

8.3.11 Pharmacy and Therapeutics Functions

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by the Joint Commission;

f. Perform practitioner analysis related to medication use;

g. Approve policies and procedures related to accreditation Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

h. Develop and measure indicators for the following elements of the patient treatment functions:

- Prescribing/ordering of medications;
- Preparing and dispensing of medications;
- Administrating medications;
- Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications;

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

8.3.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence including alcoholism or because of mental, physical or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the impaired practitioner's department chair and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the practitioners' health committee does not alter the primary responsibility of the department chair for clinical performance within that chair's department;

d. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible;

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

8.3.13 Utilization Management

a. Study recommendations from medical staff members, APPs, quality assessment coordinators and others to identify problems in utilization and the review program;

b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate clinical department or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the medical staff Quality Review committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, medical staff, and administration in matters of privileged communication and legal release of information.

ARTICLE IX MEDICAL STAFF COMMITTEES

9.1 General language governing committees

The following shall be the standing committees of the medical staff: MEC, Credentials, and Quality Review. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The president of the medical staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the president of the medical staff when establishing the committee. The president of the medical staff and the CEO, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the president of the medical staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical Staff members may be appointed to hospital committees. Actions taken by hospital committees that affect the practice of practitioners with privileges must have those actions approved by the MEC prior to going into effect.

9.2 MEC

Description of the MEC is in the Bylaws Part I: Governance; Section 6.2.

9.3 Credentials Committee

Description of the credentials committee is in the Bylaws Part III: Credentials Procedures; Section 1.

9.4 Medical Staff Quality Review Committee

9.4.1 **Composition**: The medical staff quality committee shall consist of at least five (5) members of the medical staff. Representatives from quality and hospital administration will serve as ex officio members at the invitation of the chair.

9.4.2 **Responsibilities**: The committee shall be responsible for those functions described in section 1.3.2 a-d above.

ARTICLE X CONFIDENTIALITY, IMMUNITY, RELEASES, AND CONFLICT OF INTEREST

10.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

10.2 Immunity from Liability

- No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made, within the scope of his/her duties as an official representative of the hospital or medical staff. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded by this provision shall not apply if it is established by clear and convincing evidence that the representative claiming the immunity acted in bad faith. The immunity protections afforded in these bylaws are in addition to those provided by applicable state and federal law.

10.3 Covered Activities

10.3.1 The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

a. applications for appointment/affiliation, clinical privileges, or specified services;

b. periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

c. corrective or disciplinary actions;

d. hearings and appellate reviews;

e. quality assessment and performance improvement/peer review activities;

f. utilization review and improvement activities;

g. claims reviews;

h. risk management and liability prevention activities;

i. other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

10.4 Releases

When requested by the president of the medical staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

10.5 Conflict of Interest

A member of the medical staff or APP requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, current or former spouse/partner, first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a practitioner's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.