

REDWOOD MEMORIAL HOSPITAL

MEDICAL STAFF

# RULES & REGULATIONS

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**MEDICAL STAFF RULES AND REGULATIONS  
REDWOOD MEMORIAL HOSPITAL**

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## **INTRODUCTION**

### **RELATIONSHIP TO MEDICAL STAFF BYLAWS**

These Rules and Regulations are to serve as a part of the Medical Staff Bylaws and, therefore, shall be interpreted so as to be consistent with the Medical Staff Bylaws.

## **ARTICLE 1 CONDUCT OF CARE**

### **1.1 PROVISIONS FOR CONTINUOUS MEDICAL COVERAGE**

In accordance with the Bylaws, Practitioners will provide the Hospital with on-call physician coverage of their Hospital practice during periods of planned absence or unavailability.

#### **1.1-1 Coverage Mechanism**

The Medical Staff has determined that each Medical Staff member shall abide by the following coverage mechanism:

a. **Inpatients**

With respect to the care of inpatients at the Hospital, physicians shall be called in the following order: attending physician or physician designated as being on-call for the attending physician; appropriate service group Chair; then, the Chief of Staff.

b. **Emergency Room Patients**

With respect to the care of emergency room patients at the Hospital, physicians shall be called in the following order: emergency room physician; attending physician or physician designated as being on-call for the attending physician.

- i. On-call physicians may not request information regarding a patient's ability to pay for services rendered prior to providing care.
- ii. On-call physician response time will be consistent with the patient's needs. In situations where medical intervention or emergency surgery may be required to stabilize the patient, in person response time will generally not exceed 45 minutes from the time the ED physician deems the patient unstable and contacts the on-call physician. In cases where the on-call physician is unavailable, department policy will be followed.
- iii. On-call physicians may not refuse to provide medical care for a patient who requires specialty services as defined by the Emergency Department physician and within the specialty physician's scope of practice and competency.

### **1.1-2 Transfer to Another Physician**

If management of a patient is to be transferred to another physician, the admitting physician must so state in clear terms on the progress sheet and order sheet of the chart. Additionally, the nursing staff must be informed, and they will notify the admitting department so that a proper change in records can be made. If a physician is to assume responsibility for the care of a patient of another attending physician, whether because of absence or call schedule or transfer, it is the responsibility of the original attending physician to ensure that the physician assuming care has the required clinical privileges and skill to care for that patient.

## **1.2 CONSULTATION**

### **1.2- 1 Qualification of Consultant**

Any Medical Staff member with Privileges in this Hospital can be called for consultation within his or her area of expertise.

Qualified physicians who are not members of the Medical Staff may be called in consultation provided they have secured temporary privileges as provided in the Medical Staff Bylaws.

### **1.2-2 Requirements for Consultation**

Except in an emergency, consultation with a member of the Active, Associate or Provisional Medical Staff shall be required in all major cases involving:

- a. critically ill patients, surgical patients who are high risk, patients with difficult or obscure diagnoses, or patients for whom there is doubt as to the best therapeutic measures to be utilized.

And

- b. patient's needs exceed the privileges of the practitioner.

The consultation request must include the specific question or problem to be addressed by the consultant. The referring physician will clearly indicate to the consultant the expectation of the consultant.

Unless otherwise specified, it is expected that all patients will be seen within 24 hours of a request.

In the case of transfer of primary attending care responsibility to another physician/service, the record will clearly indicate whether the transferring physician or service retains order-writing capacity.

Whenever possible, a personal communication between the consultant and the requesting physician must occur and the consultant's medical record entries shall document the reason for the consultation, show evidence of a review of the record, an appropriate history, exam, data review as well as the consultant's

impression and recommendations. Consultations shall include sufficient detail to facilitate the interpreter's review.

### **1.2-3 Right to Request Consultation**

- a. The President reserves the right to request a consultation. If the President has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, the President will call this to the attention of the Chief of Staff. Where circumstances are such as to justify such action, the Chief of Staff may require a consultation.
- b. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained and he/she has discussed this with the attending physician without satisfaction, he/she shall call this to the attention of the appropriate nursing director who, in turn, may refer the matter to the COO. If warranted, the COO may bring the matter to the attention of the service wherein the practitioner has clinical privileges. Where the circumstances justify such action, the Chair of the Service may request a consultation after discussing the case with the practitioner.

### **1.2-4 Content**

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

## **1.3 ADMISSIONS**

### **1.3-1 General**

- a. A patient may be admitted to the Hospital only by a Medical Staff member. Unless indicated on a privilege sheet, admitting includes privileges to admit to the ICU. All Practitioners shall be governed by the official admitting policy of the Hospital.
- b. Except in case of emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
- c. Podiatrists and dentists with Privileges may, with co-admission of an appropriate physician, initiate the procedure for admitting a patient. This co-admitting physician shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination and discharge summary. Patients

admitted to the Hospital for podiatric and dental care must be given the same basic appraisal as patients admitted for other services.

- d. All patients admitted to the Hospital shall have a Medical Staff member responsible for their admission, care, and discharge. Patients without an established relationship with a Medical Staff member will be cared for by the physician assigned to the first call responsibility of the Emergency Department on the day of admission.
- e. All members of the Redwood Memorial Hospital Medical Staff shall abide by the terms of the Notice of Privacy Practices prepared and distributed to Hospital patients as required by the Federal Patient Privacy Regulations.

### **1.3-2 Responsibilities of the Admitting/Attending Physician**

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, including prompt, complete, and accurate medical records and appropriate communication to the patient's family and referring physician. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record.

### **1.3-3 Admission of Suicidal Patient**

For the protection of patients, the medical and nursing staffs and the Hospital, certain principles are to be met in the care of the potentially suicidal patient. While it should be recognized that a potentially suicidal patient should be referred to a facility or hospital designated as appropriate for such patient, in the event that such referral is impossible, physicians caring for a potentially suicidal patient should follow these guidelines:

- a. The patient should be admitted to the Hospital with documented suicide precautions.
- b. Consultation with a psychiatrist is recommended. Further, the attending physician must offer such consultation to the patient or patient's representative.
- c. To assure the protection of the patient from self-harm, the attending physician shall order, if necessary, observation and application of restraints for the patient.

## **1.4 DISCHARGE AND HOSPITAL TRANSFER**

- a. It shall be the responsibility of the attending Practitioner to discharge his patients as soon as medically stable and reasonably practical.
- b. Patients shall be discharged only by order of the Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. A patient may be discharged by telephone order if the patient has been

seen that day by the attending physician or his/her designee, or, if the patient meets predetermined criteria.

- c. No patient will be transferred to another hospital without such transfer being approved by the responsible practitioner and being approved for admission by the receiving institution. Reasonable copies of medical records are to accompany the patient on transfer to another hospital.

## **1.5 MEDICAL SCREENING EXAMINATIONS**

The medical screening examination is an ongoing, continuous process which includes screening examination, stabilizing treatment, and transfer as appropriate.

The following practitioners are authorized to conduct a medical screening examination to determine if an emergency medical condition exists:

### **1.5-1 Emergency Department**

Physician members of the Medical Staff.

### **1.5-2 Labor and Delivery**

- a. Physician members of the Medical Staff who have obstetrics privileges.
- b. Certified Nurse Midwives who are employees and/or who have privileges as Allied Health Practitioners and are operating under an approved Standardized Nursing Procedure.
- c. Registered Nurses who are employees, have completed the competency program, and are operating under an approved Standardized Nursing Procedure.

## **1.6 MEDICAL RECORDS**

### **1.6-1 General**

The attending physician shall be responsible for the preparation of a complete medical record for the hospital files. This record shall include the history and physical examination, special reports (consultation, laboratory, x-ray, etc.), any laboratory reports or other diagnostic procedures performed on the patient immediately prior to admission to the Hospital which are pertinent to the diagnosis and treatment, adequate progress notes, final diagnosis and condition on discharge, and a discharge summary which should recapitulate the significant findings and events of the patient's hospitalization, his or her condition on discharge, and the recommendations and arrangements for future care. Any H&P or discharge summary completed by a practitioner other than an LIP must be validated and countersigned by an LIP with appropriate privileges within 14 days of discharge.

The pre-procedure vital signs, and the interval note updating the H&P may constitute the immediate reassessment.

## 1.6-2 History and Physical

It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care, as well as prior to "operative and complex invasive procedures" (*further defined as procedure*) in either an inpatient or outpatient setting.

Patients requiring an H&P will receive a full H&P, an abbreviated H&P, or an update note as set forth in these rules and regulations by a Medical Staff member with appropriate privileges.

An H&P which has been performed by someone who is not authorized/privileged by the Medical Staff/Hospital may be used provided that a Medical Staff member with the appropriate privileges reviews the H&P examination document, conducts a second assessment to confirm the information and findings including current physical/psycho-social status, updates any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period) and signs, dates/times the information as an attestation to it being current.

The H&P must be physically present prior to the procedure, either on the paper record or in the electronic medical record (EMR). When the H&P examination report is not present before any elective procedure, the procedure will not proceed until the appropriate H&P documentation is present. If this does not occur, the procedure will be canceled.

The minimum required content of each H&P is noted below:

### Full H&P

A full H&P is defined as an H&P that contains the following data elements:

- A chief complaint; reason for admission
- Details of the present illness
- Past medical and surgical history, including medications and allergies
- Relevant past psycho-social history (appropriate to the patients age)
- Relevant past family history
- A physical examination inventoried by body systems. Unless relevant to the chief complaint or necessary to establish diagnosis, a pelvic and/or rectal exam need not be performed.
- An osteopathic musculoskeletal examination is required as an integral part of the history and physical performed by osteopathic physicians on their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination is document in those cases where this examination is contraindicated.
- A statement on the conclusions or impressions drawn from the H&P examination.
- A statement on the course of action planned for the patient for that episode of care.

### Abbreviated H&P

An abbreviated H&P is defined as an H&P that contains the following data elements:

- A chief complaint
- Details of present illness
- Relevant past medical and surgical history pertinent to the procedure being performed, including medications and allergies
- Relevant past psycho-social history pertinent to the procedure being performed
- A relevant physical examination of those body systems pertinent to the procedure performed, but including at a minimum an appropriate assessment of the patient's cardio-respiratory status
- A statement on the conclusions or impressions drawn from the H&P examination
- A statement on the course of action planned for the patient for that episode of care

#### Update Note

An update note is defined as a statement entered into the patient's medical record that the H&P was reviewed and that;

- There are no significant changes to the findings contained in the H&P since the time it was performed, or
- There are significant changes and such changes are subsequently documented in the patient's medical record.

While it is recommended that the update note be documented on or appended to the H&P, documentation may be entered anywhere in the medical record. For patients undergoing outpatient procedures, in addition to the update note, it is required that the patient must be re-examined with attestation of the re-examination and documentation of changes if applicable.

The requirement as to which type of H&P must be performed, and associated time frames are noted in the following table:

PATIENT TYPE	H&P REQUIREMENTS
Inpatient Admission Except OB Admissions for Vaginal Delivery	A full H&P is required. The H&P must be completed no more than 30 days prior to or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.
Inpatient Procedure	A full H&P is required. If the procedure is performed more than 24 hours after admission, then the admission H&P is considered the procedure H&P. No update is needed since the physician progress notes constitute an "updating" of the patient's condition.  If the procedure is to be performed within the first 24 hours of admission, but an admission H&P has not been done, then an H&P must be completed on the day of and prior to the start of the procedure after the patient is admitted. In an emergent situation, the H&P should be completed as soon as possible after the procedure.  If the procedure is to be performed within the first 24 hours of admission, and an H&P was done prior to admission, then an update note must be entered into the record on the day of and prior to the start of the procedure after the patient is admitted. In an emergent situation, the update note should be completed as soon as possible after the procedure.

Outpatient Procedure	<p>A full or abbreviated H&amp;P is required. The H&amp;P must be completed no more than 30 days prior to or on the day of and prior to the start of the procedure after the patient is admitted.</p> <p>If the H&amp;P was performed within 30 days prior to the procedure, an update note and attestation of re-examination must be entered into the record on the day of and prior to the start of the procedure after the patient is admitted.</p>
OB Admissions for Vaginal Deliveries	<p>A full H&amp;P, abbreviated H&amp;P, or the patient's prenatal record is required. The H&amp;P must be completed no more than 30 days prior to admission or within 24 hours after admission.</p> <p>If the H&amp;P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.</p> <p>If the patient's prenatal record is used in lieu of an H&amp;P, the last entry on the prenatal record must be within 30 days of admission and an update note must be entered into the record within 24 hours after admission. The prenatal record must be legible and transferred to the hospital before admission. Otherwise, an H&amp;P must be done.</p> <p>Completion of the newborn record shall constitute an adequate medical history and physical assessment for newborns.</p>

#### Oral and Maxillofacial Surgeons

Oral and Maxillofacial Surgeons may perform an H&P if they possess the clinical privileges to do so in order to assess the medical, surgical, and/or anesthetic risks of the proposed operative and/or other procedure.

#### Dentists & Podiatrist

Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry and podiatry whether or not they are granted clinical privileges to take a complete history and perform a complete examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so. If the Dentist or Podiatrist does not possess such privileges, then a qualified Physician must perform the H&P.

#### Licensed Dependent Practitioners

If a licensed dependent practitioner (e.g. physician assistant, nurse practitioner, etc) is granted privileges to perform part or all of an H&P, the findings and conclusions are confirmed or endorsed by a qualified Physician.

### **1.6-3 Progress Record**

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on all acute-care patients.

### **1.6-4 Operative Reports**

Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be dictated

or legibly handwritten by the surgeon immediately following surgery. The operative report is to include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, postoperative diagnosis, condition of patient at end of surgery, and estimated blood loss. Immediately following completion of the procedure, the surgeon will complete a progress note to include the postoperative diagnosis, surgery performed, estimated blood loss, condition of the patient at the end of surgery, the name of the surgeon, and any information required to provide continuing care for the patient.

#### 1.6-5 Physicians' Orders

- a. **General.** All previous orders are canceled when patients go to surgery.
- b. **Written.** Practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or unclearly written will not be carried out until clearly understood by the nurse. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the responsible Practitioner or, in his or her absence, signed by the Practitioner designated by him or her to care for the patient.
- c. **Verbal.** Verbal orders may be received and recorded according to Hospital policies and procedures. Orders dictated over the telephone shall be signed by the person who received the telephone order with the name of the ordering physician accompanying his or her own name. The medications ordered must be limited to those approved by the Medical Staff. Verbal orders for diagnostic laboratory, x-ray, dietary, and cardio-respiratory services may be received by employees for the appropriate department when these orders are clearly from a person recognized as an authorized representative of a Medical Staff member at his or her direction. The use of verbal medication orders is confined to telephone orders and circumstances where expeditious administration of medications would be best facilitated by verbal communication e.g. Code Blue.
- d. **Standing, Specialty, or Protocol Orders.** Standing orders, specialty orders, protocol orders or a Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet in the patient's record, dated and signed by the Practitioner. Standing orders shall be reviewed and authenticated by the physician on an annual basis.

#### 1.6-6 Authentication

All entries and written orders in the patient's medical record shall be legible, accurately dated, timed, and signed by the responsible Practitioner. All verbal and telephone orders must be authenticated by the ordering physician within 48 hours by the prescriber or the covering physician.

#### 1.6-7 Final Diagnosis

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of all patients.

The physician will include the principal diagnosis for each patient hospitalized. The principal diagnosis is that condition which, following study, was found to be responsible for the patient's condition.

#### **1.6-8 Discharge**

- a. A discharge summary shall be written or dictated at the time of discharge for all inpatient hospitalizations. The content of the discharge summary shall be sufficient to justify the admission, the discharge diagnosis and warrant the treatment of the patient. The discharge summary shall include the following information: admission diagnosis; discharge diagnosis, including the principal diagnosis and all secondary diagnoses; operations performed; consultations performed; a summary of laboratory, radiology and other studies performed; patient's course in the hospital, including response to treatment; condition on discharge; plans for follow-up care; medications on discharge; and dietary and activity restrictions (if any). The discharge summary will be signed by the dictating physician.

For outpatients, the medical record shall contain the following information: admission diagnosis, discharge diagnosis (including principal diagnosis and all secondary diagnoses), operations performed, patient's response to treatment, condition on discharge, plan for follow up care, medications on discharge, and dietary and activity restrictions (if any).

- b. All summaries shall be signed by the responsible physician.
- c. A copy of the discharge summary shall be sent to the medical Practitioner and/or agency responsible for the subsequent care of the patient.

#### **1.6-9 Completion of the Medical Record**

- a. The medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Medical Quality Steering Committee.
- b. Each week, a list of incomplete records will be prepared by the Health Information Management (HIM) Department and sent to each physician.
- c. If the physician has any records that are delinquent (incomplete more than fourteen (14) days from the patient's discharge), the HIM Department will suspend the physician. Each suspended physician will be notified via fax and a telephone call to the office that they are suspended. In addition, appropriate hospital departments will be notified via e-mail. Privileges will be reinstated upon completion of all delinquent records. Should a delinquency be for a dictation, the physician will be removed from suspension when the report is dictated. The physician will have three (3)

working days to sign the report after it is transcribed, or the physician will again be suspended.

- d. Suspensions will not be implemented in the following circumstances:
  - i. Physician is on vacation, ill, or similar extended absence of more than one week. If the physician will be on vacation, the physician must have made a good faith effort to complete all of his/her charts. A "good faith effort" requires the physician to notify HIM of the vacation and come in within two days prior to departure and complete all outstanding records furnished by HIM. Upon return from said absence, the physician shall have three (3) working days to complete all delinquent records or the physician will be suspended. The provision does not apply to physicians who are routinely scheduled off duty, such as Emergency Department physicians.
  - ii. A physician who is newly assigned responsibility of an existing delinquent record. In such cases, the physician will have an additional four (4) working days to complete that record.
  - iii. The record is not available to the physician for completion when he/she has visited HIM within five (5) working days prior to the suspension date.
- e. In accordance with Title 22 regulations, special conditions must apply to History and Physical Examinations and Operative Reports.
  - i. History and Physical Examinations must be on the patient's record within twenty-four (24) hours of admission. If the physician dictates on the hospital's dictation system, the physician's responsibility will be fulfilled if the report is dictated within 24 hours of admission. If the physician chooses to handwrite or dictate on a system other than the Hospital's, the history and physical must be on the patient's medical record within 24 hours of admission to fulfill the physician's responsibility. If the history and physical is not completed in the above manner, the physician will be automatically suspended until the history and physical examination is dictated on the hospital's system or is physically present, if not dictated on the hospital's system.
  - ii. Operative Reports must be dictated immediately following any operation or procedure. If the physician dictates on the hospital's dictation system, the physician's responsibility will be fulfilled if the report is dictated immediately after the procedure. If the physician chooses to handwrite or dictate on a system other than the Hospital's, the operative report must be on the patient's medical record within 24 hours to fulfill the physician's responsibility. If the operative report is not completed in the above manner, the physician will be automatically suspended until the operative report

is dictated on the hospital's system or is physically present, if not dictated on the hospital's system.

- f. A suspended physician will not be permitted to admit, consult on, perform schedule surgery on, write orders, or schedule new patients, except in the event of a medical emergency. Should a suspended physician attempt to admit, schedule, or treat a patient, the Hospital staff will notify the Administrative Supervisor who in turn will notify the Chief of Medicine or Chief of Surgery based on the service group of the suspended physician. If the Chief of Service is not available, the Chief of Staff will be contacted, if not available, the Vice Chief of Staff. The Chief contacted will then contact the suspended physician and determine whether to continue or rescind the suspension based on patient care need. If a physician accumulates 31 days of suspension within a calendar year, he or she will be reported to the MEC, who will determine if it adversely affects quality of care and should be reported to the Medical Board of California. Should the suspension remain in effect for 2 months, the responsible Practitioner shall be deemed to have resigned from the Medical Staff, and to have relinquished his or her Privileges, in accord with the Medical Staff Bylaws.
- g. The American Joint Committee on Cancer staging form, when it is required, must be completed by the physician before the record is considered complete.

#### **1.6-10 Access to the Medical Record**

- a. Access to the medical records on an individual patient shall be afforded to the member of the Medical Staff for periods during or before the time at which he attended that patient. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.
- b. Access to all patient records shall be afforded to the President, Chief of Staff, service group Chairs, and Medical Staff committees when these records are used to review quality of care or utilization of hospital resources and to other Practitioners at the request of the Chief of Staff and the President.
- c. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study when done in a manner consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the administrator and the MEC before records can be studied. Such access shall also be afforded committees of the Medical Staff. Subject to the discretion of the President, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

#### **1.6-11 Release/Removal of Medical Records**

- a. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the President.
- b. Unauthorized removal of charts from the Hospital is grounds for withdrawal of staff Privileges of the Practitioner for a period to be determined by the MEC.
- c. Written consent of the patient is required for release of medical information to persons or agencies not otherwise authorized by law or statute to receive this information.

## 1.7 DEATHS

### 1.7-1 Hospital

In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his or her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a Medical Staff member, or his or her designee. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course had already been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

### 1.7-2 Autopsies

Every Medical Staff Member shall be actively interested in securing autopsies consistent with autopsy criteria established by the Medical Staff. No autopsy shall be performed without legal written consent.

## 1.8 MEDICATIONS

- a. All medications and I.V. solutions will be renewed according to Medical Staff Bylaws and related documents.
- b. I.V. solutions will be reordered every three (3) days in conjunction with I.V. medication renewals. **EXCEPTION:** Hyperalimentation and intra lipids must be reordered daily.
- c. I.V. additives and any I.V. push or I.V. piggyback medications must be reordered every three (3) days.
- d. Oral anticoagulants, antibiotics, narcotics, or hypnotics must be reordered every five (5) days.
- e. Orders that specify total days or doses of therapy will be handled as ordered.

- f. All prior drug orders are canceled when the patient is transferred to another department.
- g. Hold orders must specify the date and time of restart. If the date and time are not specified, this order will be considered an order to discontinue.

## 1.9 STERILIZATION AND ABORTIONS

The Medical Staff will meet the intent of the Ethical and Religious Directives for Catholic Health Facilities as interpreted by the MEC.

## ARTICLE 2 PEER REVIEW

**2.1 PROCESS.** The medical staff screen patient care for its quality and appropriateness through the following mechanisms:

- Medical staff approved criteria for appropriateness and effectiveness.
- Incident reports and/or Statements of Concern as they relate to physician issues.
- Patient and/or family complaints as they relate to quality of care issues.
- Third party payor/outside regulatory or accreditation agencies notices.
- Any staff concern referred for peer review.

The process for initiating peer review may occur in the following two methods:

**Fast Track Review.** Fast track review for any circumstances (clinical or behavioral) identified by hospital administration, Medical Staff leadership, or Quality/Risk Management in which the lack of immediate intervention would have the potential to adversely effect the health and/or safety of a patient, family, staff or visitor.

**Routine Review.** Routine review for those clinical and/or behavioral situations where the immediate action of medical staff leadership is not required.

The medical staff service groups are responsible for performance of peer review activities under the leadership of the Service Chairpersons.

**Peer reviewers** are defined as individuals from the same professional discipline as the reviewee, and when possible, are practitioners in the same specialty or a related specialty who possesses sufficient training and experience to render a technically sound judgment on the clinical circumstances under review. For purposes of reviewing a practitioner's behavior, a peer reviewer may be any member of a service group, another member of the medical staff appointed by the medical staff leadership, and/or a medical staff leader.

In extenuating circumstances, the medical staff may request review by a peer who is not a member of the medical staff (external peer review). Peers may be sought through local county or state medical societies, academic institutions or individual(s) in the community who are members of another hospital's medical staff. Examples of extenuating circumstances include:

- a. When there is no suitable peer reviewers on the medical staff.
- b. When a limited number of peers exist on the medical staff making it difficult for the medical staff leadership to obtain an objective review which is free from conflict of interest.

## 2.2 FAST TRACK REVIEW

**2.2-1 Steps.** The following steps will be completed during a fast track peer review event.

- a. Hospital Administration, Medical Staff Leadership, or Quality / Risk Management identifies an event requiring immediate intervention.
- b. Within 24 hours the following activities will be completed:
  - i. The Medical Records Department captures and enters pertinent information about the event into the Peer Review Database and produces a Clinical Chart Review Form (CCRF).
  - ii. The Medical Records Department requests the associated medical record to be pulled if the event is referenced to a medical management incident.
  - iii. The Medical Records Department will contact the Service Chair, Chief of Staff or other appropriate medical staff leader to inform her/him of the event and request review of the case.
  - iv. Responsibilities of the Service Chair, (or other delegated medical staff leader):
    - a) Review the events of the incident with the Quality Management Staff or Hospital Administration.
    - b) Review the Medical Record, if appropriate.
    - c) Contact the involved physician to discuss the event and clarify the issues and circumstances, if clarification is required.
    - d) The Service Chair completes the CCRF and documents findings of his/her review and suggests a course of action on the CCRF.
    - e) The Service Chair may enlist, at his/her discretion, additional reviewers when technical/professional issues require further clarification.
  - v. Based on the final disposition of the review, one or more of the following actions may be taken:
    - a) The Service Chair will arrange a meeting with the involved Physician, and the Chief of Staff (if requested by the Service Chair) to discuss the issues in an effort to conclude the case and determine a final disposition.

- b) Medical staff leaders may provide education, and/or counseling if immediate action is required to prevent further incidence(s) from occurring.
- c) If, in the opinion of the Service Chair and/or other appropriate medical staff leader, there is a continued potential or real threat to patients, family, staff or visitors, summary suspension and/or other appropriate disciplinary action may be taken pursuant to Medical Staff By-laws Article IX.
- d) Trend the case if no further action is required.
- vi. The conclusion is reported on the CCRF and logged in the Abstract Committee Report of the appropriate Medical Staff Department.

## 2.3 ROUTINE PEER REVIEW THROUGH THE QUALITY REVIEW COMMITTEE MECHANISM

### 2.3-1 First Level Case Review

- a. **Steps.** The following steps will be implemented for a routine case review:
  - i. The Medical Records Department identifies an event utilizing Medical Staff approved criteria for appropriateness and effectiveness.
  - ii. The Medical Records Department screens the event and documents their findings in the peer review database.
  - iii. If a case fails the initial screening, it is flagged for further review.

### 2.3-2 Second Level Case Review

- a. **Assessment Mechanism.** Cases assigned for second level assessment are completed through the following mechanisms.
  - i. The Medical Records Department provides a Clinical Chart Review Form (CCRF) with information summarized during first level review.
  - ii. The physician reviewer will be notified by the Medical Records Department prior to the service group peer review session, notifying her/him of the Chair's request for review of case(s).
  - iii. The Medical Records Department will have the medical record pulled and the CCRF will be placed in the front of the corresponding medical record.
  - iv. The assigned charts will be located in the chart completion area, adjacent to where physicians complete their charts.

- v. Each medical record will be flagged with the assigned physician's name for easy identification.
- vi. The physician reviewer will be asked to complete the CCRF and document a summary of findings. The reviewer should suggest an outcome finding and a recommended action.

The routine peer review process should be completed no longer than sixty (60) days from assignment. The medical records department will collect the CCRF and summarize the information on a committee abstract report. All pending reviews are reported to the Medical Staff monthly to assist in ensuring that reviews are completed timely.

**b. Conclusions of Second Level Assessment - Service Group Action**

The Service Chairperson has the final decision on the outcome and recommended action(s) germane to the case. These actions include:

- i. Physician education
- ii. Written/verbal counseling for physician and/or other disciplines
- iii. Additional monitoring or other appropriate interventions
- iv. Disciplinary action as defined in the medical Staff By-laws Article IX
- v. Trending
- vi. Initiate Formal Peer Review
- vii. No further action necessary

In all cases except for when no further action is necessary, the physician shall be noticed in writing or verbally and afforded the opportunity to respond to the review.

## **2.4 FORMAL PEER REVIEW**

**2.4-1 Purpose and Definition.** A Formal Peer Review is an intensified assessment of data or event, which relate to the performance or behavior of a specific practitioner holding clinical privileges. The purpose of a Formal Peer Review is to determine if the practitioner's performance or behavior meets the minimum standard of behavior or clinical care as is established by the Medical Staff.

**2.4-2 Procedure.** If concerns are identified through First or Second Level Assessment by any committee or team in the organization regarding the behavior or clinical performance of a practitioner holding clinical privileges, that concern will be forwarded to the MEC for review by the appropriate Medical Staff service group. If the service group determines that a practitioner-specific Intensified Assessment is indicated, the service group will recommend a Formal Peer Review.

The service group may also recommend to the MEC that a Formal Peer Review is indicated based on their own review of Data or Events.

Only the Medical Executive Committee (MEC) may initiate a Formal Peer Review.

The Formal Peer Review Committee may be the MEC, the service group or, at the discretion of the President of the Medical Staff or chairperson, may be an ad hoc group consisting of members deemed to be appropriate by the Service Chairperson. Non-medical staff members may be included on the Formal Peer Review Committee when appropriate.

When a Formal Peer Review is initiated by the MEC, the following events shall occur:

- a. Involved practitioner will be given verbal or written notice by the chair of the service group, Chief of Staff, or designee regarding the specific concerns which have been identified and are the basis of initiating the Formal Peer Review. Written notice to the practitioner shall be included as an attachment to the Formal Peer Review minutes. A person giving verbal notice to the involved practitioner shall record a summary of the verbal notice, which shall be included as an attachment to the Formal Peer Review minutes.
- b. Prior to reaching a conclusion, the Formal Peer Review Committee will allow the involved practitioner to respond to the committee's concerns either in writing or by addressing the Formal Peer Review Committee in person. The practitioner being reviewed has the right to address the Formal Peer Review Committee in person if he or she so desires. If the involved practitioner does not wish to address the Formal Peer Review Committee, in writing or in person, this fact shall be noted by the Formal Peer Review Chair and recorded in the Formal Peer Review minutes.
- c. A report of the conclusions of the Formal Peer Review Committee will be reported to the MEC for action.

If the Formal Peer Review Committee requests that the involved practitioner provide additional information to the Formal Peer Review Committee either in writing or through a personal appearance, it shall be the obligation of the practitioner being reviewed to fulfill this request within a reasonable period of time.

If the recommendation of the Formal Peer Review Committee to the MEC is adverse and includes a recommended action, which would generate hearing rights as described in the Medical Staff Bylaws, the MEC shall consider the initiation of an investigation pursuant to the Bylaws, Section 9.1-6 d. prior to taking such a disciplinary action. The MEC has no obligation to implement the recommendations of the Formal Peer Review Committee and nothing in this policy shall interfere with the right of the MEC to take action without the initiation of an investigation.

#### **2.4-3 Conducting the Formal Peer Review**

- a. At RMH, a peer is considered to be any practitioner of the same licensure as the practitioner being reviewed except that all physicians are considered to be peers of all other physicians. Any Formal Peer Review

Committee shall include at least one peer of the practitioner being reviewed.

- b. When the concerns being reviewed include clinical or technical issues related to a specific specialty treatment or procedure, the Formal Peer Review Committee will include at least one peer who is a practitioner currently qualified and competent in the clinical area, specific treatment or procedure under discussion.
- c. The service chairperson and/or the Medical Executive Committee shall consider the use of external peer review when either there are no practitioners available to serve on the Formal Peer Review Committee who have appropriate clinical or technical skills, or when there is a potential conflict of interest relevant to a specific practitioner or practitioners who may otherwise be appropriate members of a Formal Peer Review Committee. External peer review may be recommended at the discretion of the Service Chairperson and this recommendation of a formal external peer review shall be submitted in writing to the Chief of Staff by the Service Chairperson.
- d. The Formal Peer Review should be concluded within 120 days of initiation. If the Formal Peer Review Committee is not able to complete the Formal Peer Review within 120 days of initiation, a report will be submitted to the MEC by the Service Chairperson regarding the status and timeliness of the Formal Peer Review.
- e. The Formal Peer Review Committee should consider minority opinions and views and the opinions and comments of the reviewee shall be considered and recorded.
- f. When appropriate, the Formal Peer Review Committee should consider utilizing objective standards, reference literature, outcomes measurement, comparative data, and relevant clinical practice guidelines in the peer review process.

### **ARTICLE 3 ALLIED HEALTH PROFESSIONALS**

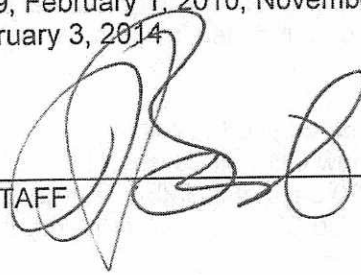
Rules and Regulations governing the status and function at this Hospital of assistants to the physicians, including Physician Assistants; Nurse Practitioners; Nurse Midwives; Certified Nurse Anesthetists; Psychologist; Licensed Clinical Social Workers; Marriage, Family and Child Counselors, are to be described under the Allied Health Professional Rules and Regulations/Guidelines.

THESE RULES AND REGULATIONS:

ADOPTED by the Medical Staff on December 20, 1999.

REVISED January 7, 2002, March 4, 2002, March 18, 2002, April 1, 2002, May 28, 2002, June 16, 2003, December 15, 2003, March 15, 2004, July 7, 2004, May 24, 2005, July 12, 2005, May 26, 2009, February 1, 2010, November 1, 2010, March 7, 2011, January 14, 2013, March 3, 2013, February 3, 2014

CHIEF OF STAFF



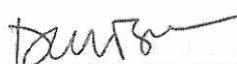
DATE

3 Mar 14

ADOPTED by the Governing Board on January 25, 2000.

REVISED January 29, 2002, March 26, 2002, May 28, 2002, January 27, 2004, August 31, 2004, May 24, 2005, July 12, 2005, September 27, 2005, May 26, 2009, February 23, 2010, December 7, 2010, March 29, 2011, January 23, 2013, March 27, 2013, February 26, 2014

GOVERNING BOARD



DATE

3/6/14