UH PARMA MEDICAL CENTER

MEDICAL STAFF

RULES AND REGULATIONS

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DEFINITIONS

The definitions set forth in the Medical Staff Bylaws shall apply to these Rules & Regulations unless a different definition is specified herein.

ARTICLE I. ADMISSION AND CARE OF PATIENTS

1.1. The Hospital shall admit patients suffering from all types of illness, injury, and/or disease for which proper accommodations and facilities are available as recommended by the Medical Executive Committee and approved by the Board.

1.2. No patients shall be admitted to the Hospital until after a provisional diagnosis has been documented.

1.3. Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients, staff, and visitors from those who are a source of danger from any cause, or to assure protection of the patient from self harm.

1.4. Practitioners shall comply with the Hospital's Smoking Policy, as such policy may be amended from time to time.

1.5. When an attending Practitioner determines that a consultant should be called in on a case, the attending Practitioner will write an order stating what specific services the consultant is to perform. While it is ultimately the responsibility of the attending Practitioner to notify the consultant, the Unit secretary or nurse will place a call to the consultant when the attending Practitioner places an order for a consultation. If the consultant cannot be reached, the Unit secretary or nurse must notify the attending Practitioner as soon as possible. Consultants are expected to respond to consultation requests within twenty-four (24) hours of the request. If the attending Practitioner feels that a more timely response is needed, he or she must specify a shorter time frame in the consultation order. The attending Practitioner must personally notify the consultant of a request for a STAT consultation.

A psychiatrist/Psychologist must be notified by the attending Practitioner that there is a patient who must be seen when, in the judgment of the attending Practitioner; the patient's medical condition permits such a consultation. Should a psychiatric/psychological consult be difficult to obtain, the chair of the Department of Medicine should be notified. Typically in cases of intentional drug overdose or suicide attempt, the attending Practitioner should consult with a psychiatrist/Psychologist in a timely fashion. For purposes of this Section, the term "timely fashion" is defined as a twenty-four (24) hour period.

1.6. All patients shall be attended by Practitioners with Privileges in the appropriate Division or Department. Unassigned patients needing admission who have no attending Practitioner shall be assigned to Practitioners on duty in the appropriate Division or Department.

Emergency medical screening examination – Qualified Medical Personnel. A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under a valid agreement with a physician member of the Hospital's medical staff:

- Certified nurse practitioners;
- Certified nurse midwives (obstetrics only);
- Physician Assistants

For non-resident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes and approval set forth in the Medical Staff Bylaws

1.7. Patients shall be discharged only on written order of the attending Practitioner.

1.8. All patients must be seen by the attending Practitioner within twenty-four (24) hours of admission with a note written.

1.9. Decision for admission to the Intensive Care Unit will be made by the on-site evaluating providers at the time of admission or transfer to the Intensive Care Unit. The on-site physician responsible for the Intensive Care Unit will be the Intensivist.

The attending of record will remain the primary care physician, on-call physician or hospitalist as determined at the time of admission.

The attending will assume care of the patient once the attending is able to evaluate and assist in the management of the patient.

The board certified/board qualified Critical Care Medicine physician will have primary responsibility for management of the admitted patient including decision regarding admission to and discharge or transfer from the ICU, decisions to intubate and extubate patients, decisions to consult with other specialists and decisions pertaining to palliative care and end of life care. The non-Critical Care Medicine board certified/board qualified practitioner may co-manage the ICU patient, however, the Critical Care board certified/board qualified practitioner will have final say on all matters pertaining to the clinical care of the patient while in the ICU. Patients admitted or transferred to critical care units are to be seen and examined by the Critical Care Medicine physician or designee within four hours of the decision to admit or transfer the patient to the unit.

1.10. All patients shall be visited daily by the attending Practitioner who will document the visit.

1.11. Individuals in training, such as medical students and residents, participate in the care of patients only under the supervision of responsible Appointees with appropriate Privileges.

ARTICLE II. ORDERS AND DRUGS

2.1. Preprinted Orders

Preprinted orders shall be formulated by the Medical Staff. They can be changed only by mutual consent of the Medical Staff. All personnel concerned shall be notified. Preprinted orders may not be altered or deleted in any manner. If a change is necessary, a new order must be entered separately in the medical record. Pre-printed orders require a physician order to be initiated (either telephone or in person).

2.2 Written, Telephone and Verbal Orders

2.2.1 Only Practitioners with appropriate Privileges who are actively treating a patient during the current Hospital visit may place orders for a patient. These Practitioners include the admitting and attending Practitioner, consultants, and covering and associated Practitioners. Practitioners providing intermittent care including, but not limited to, house officers, hospitalists functioning as house officers, and radiologists performing a radiologic procedure may also place orders for a patient. In a medical emergency, any Practitioner may place orders for a patient. Practitioners who have seen a patient on a previous visit or as an outpatient are not authorized to place orders, except as specified above.

2.2.2 All orders shall be in writing and must be timed, dated, and authenticated. An order shall be considered to be in writing if dictated to an individual authorized by the Hospital to receive and transcribe such order from the Practitioner consistent with the receiving individual's scope of authority as described below (*e.g.,* as permitted by his/her license, Privilege set, job description, *etc.*) and with applicable law.

2.2.2.1 Registered dietitians are permitted to receive and document telephone orders related to a patient's nutrition or to laboratory tests that relate to the nutritional status of a patient.

2.2.2.2 Registered Pharmacists are permitted to receive and document telephone orders for medications. Elements that should be included in any medication order include: name of patient; age and weight of patient, where appropriate; date and time of the order; drug name; dosage form (*e.g.*, tablets, capsules, inhalants); exact strength or concentration; dose, frequency, and route; quantity and/or duration; purpose or indication; specific instructions for use; and name of prescriber.

2.2.2.3 Speech therapists are permitted to receive and document telephone orders if such orders relate to a patient's speech therapy (*i.e.,* cookie swallow, bedside swallowing evaluations, and specific diets).

2.2.2.4 Licensed social workers are permitted to receive and document telephone orders for discharge disposition planning.

2.2.2.5 Physical therapists and occupational therapists are permitted to receive and document telephone orders for physical therapy and occupational therapy, respectively.

2.2.2.6 Central Registration Clerks are permitted to receive and document telephone orders for admission status.

2.2.2.7 Licensed respiratory care practitioners are permitted to receive and document telephone orders if such orders relate to a patient's respiratory therapy.

2.2.2.8 The following additional Hospital staff shall be permitted to receive and document telephone orders consistent with his/her scope of authority (*e.g.,* as permitted by his/her license, job description, *etc.*) and applicable law: Nuclear Medicine Technologists, CT Technologists, Radiologic Technologists, MRI Technologists, Mammography Technologists, Ultrasound Technologists, Medical Technologists, Medical Laboratory Technicians, Registered Nurses (RNs), Licensed Practical Nurses (LPN's) and Allied Health Professionals. Orders for radiology services shall include pertinent clinical information from the ordering Practitioner.

2.2.3 All telephone orders shall be documented in the medical record upon receipt by an individual authorized to accept such orders and shall include the date and time the order was received, the name and signature of the person documenting the order, and the name of the Practitioner who issued the order.

2.2.4 Telephone orders shall be reviewed, authenticated/countersigned, dated, and timed by the ordering Practitioner within forty-eight (48) hours after the order is issued unless otherwise specified by the Hospital.

2.2.4.1 If an ordering physician is unable to authenticate his or her order within 48 hours (*e.g..*, the ordering physician gives a verbal order which is written and transcribed, then is "off duty" for the weekend or an extended period of time), it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final.

2.2.4.2 A qualified practitioner such as a physician assistant or nurse practitioner may not "co-sign" a physician's verbal order or otherwise authenticate a medical record entry for the physician who gave the verbal order.

2.2.5 Verbal orders should be limited to urgent situations (*e.g.* code blue, already scrubbed in for a case, *etc.*) where immediate written or electronic communication is not feasible. They should be used infrequently, and they are not to be used for the convenience of the ordering Practitioner. Practitioners who exhibit unwillingness to adhere to the prohibition against verbal orders will be identified to his/her Department Chair for possible corrective action.

2.2.7 Allied Health Professionals may issue orders in accordance with the requirements set forth in this Article if such orders are within the AHP's scope of authority/practice; permitted by the AHP's Privilege set; consistent with the AHP's certificate to prescribe, standard care arrangement, or supervision agreement, as applicable; and in accordance with applicable laws and Hospital and Medical Staff policies.

2.3 Medication Orders

2.3.1 When there is a need for clarification of a medication order of a Practitioner, the pharmacist receiving the order shall contact the ordering Practitioner. When the order is clarified, it may be conveyed to the nurse by either the ordering Practitioner directly or by the pharmacist, at the discretion of the ordering Practitioner.

2.3.2 Drugs used shall be those listed in the Hospital Formulary with the exception of drugs for bona fide clinical investigations. All drugs shall meet current compendia standards.

2.3.3 Exceptions for use of non-Formulary drugs may be made with the approval of the chair of the Pharmacy & Therapeutics Committee, the chair of the Department involved; or, in their absence, a Physician member of the Pharmacy & Therapeutics Committee.

2.3.4 Only those Practitioners with Privileges to do so may prescribe medications in the Hospital. Practitioners with Privileges to prescribe shall meet all State and Federal requirements relating to or governing the prescribing of dangerous drugs.

2.3.5 Allied Health Professionals are permitted to prescribe medications, if granted Privileges to do so, appropriate to their specialty and in accordance with a current, valid certificate to prescribe.

2.3.6 The Department of Pharmacy Services shall only honor those prescriptions written, or transmitted to an authorized representative of the Hospital, by a Practitioner or AHP with the Privileges to do so.

2.3.7 A registered nurse, licensed practical nurse, registered pharmacist or respiratory therapist (for respiratory therapy drugs) shall be permitted to enter telephone medication orders into the medical record. Telephone orders for any drugs, including nonprescription medications and dangerous drugs, may be entered by an Allied Health Professional without prescriptive authority.

2.4 Authorization to Administer Medications

2.4.1 Medications are any substances defined by Federal and State statutes as a dangerous drug. In addition, over-the-counter preparations approved for use in the Hospital shall be considered medications.

2.4.2 Administration of medication shall be defined as the introduction into or the application onto the human body of a medication. Routes of administration shall include, but not be limited to, oral, parenteral, rectal, topical, and inhalation administration.

2.4.3 The following personnel are authorized to administer medications:

Personnel	Restrictions
Practitioner with appropriate Privileges	See applicable Privilege set
AHP with appropriate Privileges	See applicable Privilege set
Registered Nurse	For restrictions on general nursing units, see Nursing Manual
Licensed Practical Nurse	Requires acknowledgment/validation from a registered nurse of orders for all medications prior to administration. May not administer any intravenous or investigational medication.
Student Nurse	Under supervision of instructor in accordance with nursing policies & procedures.
Registered Radiologic Technologist	Medications and solutions used with radiologic examinations and given orally and rectally; intravenous administration of contrast agents; heparin flush.
Nuclear Medicine Technologist	Restricted to small tracer amounts of radio pharmaceuticals used in diagnostic scanning procedures given intravenously; heparin flush.

Computerized Tomography Technologist	See Registered Radiologic Technologist
Computerized Tomography Supervisor	See Registered Radiologic Technologist
Student Radiologic Technologist	See Registered Radiologic Technologist (under supervision of Program Director)
Registered Respiratory Therapist	Restricted to medications intended for inhalation; resuscitative drugs through the ET tube per Code Pink protocol; sympathomimetic bronchodilators and mucolytics via the endotracheal tube.
Respiratory Therapy Technician	See Registered Respiratory Therapist
Respiratory Therapy Assistant	See Registered Respiratory Therapist
Student Respiratory Therapist	See Registered Respiratory Therapist
Licensed Physical Therapist	Restricted to topical agents
Licensed Occupational Therapist	Restricted to topical agents
Paramedic Instructors	Restricted to medications approved in the paramedic curriculum or administered under the direct supervision of a Physician or registered nurse or AHP at the discretion of a Physician.
Paramedic Students	Restricted to medications approved in the paramedic curriculum or administered under the direct supervision of a Physician or registered nurse or AHP at the discretion of a Physician.
Hospital Employed Paramedics in the Emergency Department	Restricted to medications approved by State-mandated paramedic curriculum and under the supervision of a registered nurse or AHP.
Perfusionist	All medications related to cardiopulmonary bypass under the supervision of a surgeon or Physician in charge.

Dialysis Technician	Heparin; normal saline; may add potassium, calcium to dialysate solution under the overall supervision of a registered nurse.

2.5 Authorization for Use of Restraints and Protective Devices

Practitioners will comply with the Hospital's Restraint Policy, as such policy may be amended from time to time.

2.6 PICC Line Placement Policy/Procedure

In order to provide the best management for intravenous access and provide efficient placement of PICC lines, the following policies and procedures are adopted:

Indications for PICC lines:

- Long term antibiotic therapy
- Long term TPN
- Compromised or poor peripheral venous access

Requests for PICC lines must be placed (ordered in writing) by 12 Noon, Monday through Friday or at least 24 hours before a scheduled discharge or at least 48 hours before discharge scheduled for a Saturday, Sunday or Holiday. Requests for "emergency" PICC lines must be communicated by the requesting physician by phone directly with the radiologist on call.

ARTICLE III. MEDICAL RECORDS

3.1 Attending Practitioner's Responsibilities

3.1.1 The attending Practitioner shall be held responsible for the preparation of a completed medical record for each patient including a discharge summary. This record shall contain information that reflects the patient's care, treatment, and services including, but not limited to: identification data; the patient's personal history, family history, and history of present illness; physical examination; special reports such as consultations, clinical, laboratory, x-ray and others; provisional diagnosis; medical or surgical treatment; operative report; pathologic findings; progress notes; autopsy report when available; and, such other information as required by applicable law and accreditation standards. At the time of discharge, the attending Practitioner shall see that the record is complete, state his/her final diagnosis, and authenticate the record. No medical record shall be filed until it is complete except on order of the Medical Records Committee.

3.1.2 All medical record entries must be dated, timed, and authenticated. Authentication of medical record entries may include written signatures, initials, computer key, or other code as approved by the Hospital.

3.2 History and Physical Exam

3.2.1 Requirements related to completion and documentation of a medical history and physical examination (H&P) are set forth in Section II(B) of the Medical Staff Bylaws.

3.2.2 The H&P and any updates thereto must be in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

3.2.3 In the event an update to the H&P is required as detailed in the Medical Staff Bylaws, the update shall be based upon an appropriate reassessment of the patient which should include a physical examination of the patient sufficient to update those components of the patient's current medical status that may have changed and to address any areas where more current data is needed since the H&P was completed.

3.2.4 In the event of a medical emergency that requires surgery or a procedure requiring anesthesia services, when the H&P has been dictated but is not yet present in the patient's medical record, the Practitioner who admitted the patient shall write a statement to that effect as well as an admission note in the medical record. The note should include, at a minimum, critical information about the patient's condition including pulmonary status, cardiovascular status, blood pressure, and vital signs. Such circumstance is acceptable only in a medical emergency and is not applicable for a scheduled surgery.

3.2.5 Handwritten histories and physicals are not acceptable. A typed history and physical from a Practitioner's office is acceptable, provided the time frames specified in the Medical Staff Bylaws are met.

3.2.6 Inpatient Medical Records

3.2.6.1 Inpatients are defined as acute, skilled, rehabilitation, and geropsychiatric patients.

3.2.6.2 All inpatient histories and physicals for non-nursery patients must be dictated.

3.2.6.3 The history and physical and discharge summary for all non-nursery inpatients must be separate documents.

3.2.6.4 A complete admission history and physical contains documentation as follows:

3.2.6.4.1 Medical history, (chief complaint, present illness, relevant past, social, and family histories (age appropriate), inventory of body

systems, review of medication reconciliation, allergies, diagnostic impression.

3.2.6.4.2 A summary of psychosocial needs, as appropriate to the patient's age.

3.2.6.4.3 A report of relevant physical examination.

3.2.6.4.4 A statement of the conclusions or impressions drawn from the admission history and physical exam.

3.2.6.4.5 A statement on the course of action planned for the patient, the goals of treatment and the treatment plan for this episode of care.

3.2.7 Procedures Requiring General Anesthesia, Regional Anesthesia, IV (Moderate/Conscious) Sedation, and Monitored Anesthesia Care (MAC)

With the exception of an emergency, as noted above, a current and complete history and physical shall be performed and documented in the medical record in accordance with the requirements set forth in the Medical Staff Bylaws and this Section prior to a procedure requiring general anesthesia, regional anesthesia, IV (moderate/conscious) sedation, or monitored anesthesia care.

3.2.8 Local Anesthesia (Analgesia)/Outpatient Surgery Medical Records

A current and relevant history and physical examination may be included but is not required on the medical record.

3.2.9 Podiatric and Dental Patients

The requirements for completing and documenting a medical history and physical examination for dental and podiatric patients are set forth in Section II(B) of the Medical Staff Bylaws.

3.2.10 Recurring Outpatients

3.2.10.1 Recurring outpatients are defined as patients requiring oncology, pain management, cardiac rehabilitation, or physical/occupational therapy services or wound therapy.

3.2.10.2 Recurring outpatients are not required to have a history and physical; however, documentation of the patient's current medications, allergies and significant surgical procedures is required. This information is to be updated yearly.

3.3 Operative Reports/Other High Risk Procedure Reports *

* Other High Risk Procedure Reports include, but are not limited to: endoscopy reports, cardiac catheterizations, electrophysiology studies (EPS), pacemaker insertions, and interventional radiology procedures.

3.3.1 All surgical procedures must have a dictated operative report.

3.3.2 Operative Post Procedural Note

3.3.2.1 Immediately following a procedure, a post procedure note is required for all patients.

3.3.3 The operative report should be dictated immediately after surgery.

3.3.3.1 The operative report will contain at least the following: name and Hospital identification number for the patient; date and time of the surgery; name(s) of the surgeon(s)/Practitioner(s) and assistants or others who performed surgical tasks (even when performing those tasks under supervision); pre-operative and post-operative diagnosis; name of the specific surgery performed; type of anesthesia administered; complications/estimated blood loss; a description of techniques, findings, and tissues removed or altered; surgeons' or Practitioner's names and a description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner (significant surgical tasks include: opening and closing; harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and prosthetic devices, grafts, tissues, transplants, or devices implanted.

3.3.3.2 The operative report shall be timed, dated, and authenticated by the responsible surgeon/Practitioner.

3.3.4 If the Practitioner cannot dictate the operative report immediately after the surgery, an interim post-operative note must be recorded and placed in the medical record.

3.3.4.1 The post-operative note shall include: the surgeon/Practitioner and assistants; the pre-operative and post-operative diagnosis; surgery performed; specimens removed; estimated blood loss/blood administered; any complications; type of anesthesia administered; and grafts or implants.

3.3.4.2 The post-operative note must be available in the medical record before the patient is transferred to the next level of care (*e.g.* before he/she leaves the post anesthesia care unit) and shall be authenticated, dated, and timed by the responsible surgeon/Practitioner.

3.3.5 All operative reports must be dictated within forty-eight (48) hours of the time the procedure is completed.

3.3.6 Failure to dictate an operative report within forty-eight (48) hours of the procedure will result in an automatic suspension of the Practitioner's surgical Privileges until such time as the operative report is dictated; provided, however, that the Practitioner may attend to the management of any patient under the Practitioner's care whose surgery was previously scheduled to occur within twenty-four (24) hours after the effective date of the suspension. Health Information Services (HIS) will contact the Practitioner for an operative report not dictated within forty-eight (48) hours. The Practitioner will have forty-eight (48) hours from the time he/she is contacted by HIS to dictate the operative report. The chair of the Department of Surgery will be notified if the Practitioner does not comply. The President of the Medical Staff, in addition to the chair of the Department of Surgery, will be notified if the operative report has not been dictated within five (5) days after the procedure date. Failure to dictate an operative report within seven (7) days after the procedure constitutes grounds for the initiation of corrective action.

3.4 Emergency Department Records

Emergency Department records must be completed by the Practitioner in attendance within forty-eight (48) hours of providing care, treatment, or services to the patient.

3.5 Anesthesia Services

3.5.1 A pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services.

3.5.2 A post-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with Hospital policies and procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care.

3.6 Discharge Summary

3.6.1 All inpatients must have a discharge summary dictated except for the following categories:

3.6.1.2 Patients whose stay is less than 24 hours in duration

3.6.1.3 Routine newborn stays

3.6.1.3 Uncomplicated vaginal deliveries that have been discharged within 48 hours and have not had any surgical procedures.

3.6.2 Discharge summaries will be performed at the time of discharge from the hospital or as soon afterwards as possible but no later than 72 hours from discharge. A

discharge summary may be dictated 24 hours prior to discharge; however, a progress note and discharge order must be written on the day of discharge. The discharge summary must include:

3.6.2.1 The reason for the hospitalization

3.6.2.2 The procedures performed

3.6.2.3 The care, treatment and services provided

3.6.2.4 The patient's condition and disposition at discharge

3.6.2.5 Provisions for follow-up care and instructions given to the patient and/or family, particularly in regard to physical activity, limitations, medications and diet.

3.6.2.6 Final diagnosis(es) must be listed in order of principal and secondary diagnoses. Symptoms must not be used unless specified as undiagnosed.

3.7 Progress Notes

Advance and backdating of progress notes is prohibited. Progress notes are to be authenticated with current date and time.

The progress note should include a statement of the conclusions or impressions and a statement on the course of action planned for the patient for this episode of care.

3.8 Electronic Signature of Transcribed Documents

All documents which have been dictated must be electronically signed. Electronic signature will be defined in the Hospital administrative policy manual, as such policy manual may be amended from time to time.

3.9 Computerized Provider Order Management (CPOM) Universal Adoption

3.9.1 All clinicians will be required to use the Electronic Health Record (EHR) and transition from the paper chart to the EHR according to the EHR roll-out schedule as outlined by the EHR Committee, including universal adoption of CPOM and Physician Documentation (PDOC).

3.9.2 Each member of the Medical Staff is required to be trained in the use of the electronic health record.

3.9.3 The required training will be determined by the Medical Executive Committee upon recommendation of the Electronic Health Record Committee.

3.9.4 Training must be completed by new members of the Medical Staff before they can exercise their privileges.

3.9.5 Existing members of the Medical Staff will be subject to suspension of their clinical privileges if the required training or demonstration of competency is not completed by a date determined by the Medical Executive Committee.

3.10 MEC Determination

The Medical Executive Committee will determine what documents in the medical record require mandatory completion. This information will be conveyed to the members of the Medical Staff to ensure compliance.

3.11 Completion of Records and Automatic Suspension

Practitioners shall have thirty (30) days from the date of patient discharge to complete all available medical records, after which time incomplete medical records will be considered delinquent. A completed medical record is defined as a record that has all required elements and signatures as described in the Rules and Regulations. Since, in the course of business, a medical record may be unavailable to a Practitioner for completion, such records, although still considered incomplete/delinquent, will not be incorporated into the Practitioner's record count until returned to Health Information Services.

3.11.1 On the first business day of each month, the Health Information Services Department, on behalf of the President of the Medical Staff and the chair of the Medical Record Committee, will send written notification to each Practitioner a list of all records requiring completion by the physician and the urgent need to complete all delinquent records before 5:00 p.m. on the Wednesday before the next Medical Executive Committee meeting.

3.11.2 On the 15th of each month (or the first business day thereafter), any Practitioner who has not completed his/her records will receive another written notification to remind them of the need to complete all records before 5:00 p.m. on the Wednesday before the next Medical Executive Committee meeting.

3.11.3 Health Information Services will complete analysis of all records on Thursday before the Medical Executive Committee meeting and submit a list of any Practitioners that have failed to complete delinquent records to the Medical Executive Committee. A delinquent medical record is defined as a medical record that is incomplete thirty (30) days post-patient discharge.

3.11.4 A Practitioner with delinquent medical records who chooses not to comply with the requirements of these Rules and Regulations regarding record completion by 5 p.m. on the Wednesday before the next regularly scheduled Medical Executive Committee meeting shall, pursuant to the Bylaws Section X(A)(6)(g), have his/her Clinical Privileges automatically suspended as of the date of the Medical Executive Committee meeting. Practitioners with suspended Privileges may not:

3.11.4.1 Schedule or perform any surgical or specialty procedure.

3.11.4.2 Perform consultations

3.11.4.3 Read Cardiovascular Services reports

3.11.5 In the event of a need for the Emergency Department to contact a Practitioner with suspended Privileges, such Practitioner's designated alternate, as provided to the Medical Staff Office, will be contacted for consultation and, if necessary, for admission. No Practitioner with suspended Privileges will be allowed to assume care of a patient after admission, until the Practitioner's Privileges are reinstated. Practitioners whose Privileges are automatically suspended for failure to complete medical records must notify their designated alternate Practitioner of the need to be available to admit and care for patients needing admission from the Emergency Department.

3.11.6 In the event of an automatic suspension under the Bylaws, the President of the Medical Staff or MEC designee will contact the suspended physicians on the Tuesday following MEC to inform them of their suspension(s). The President or MEC designee will inform the suspended physician(s) that they may not admit any Hospital patient; perform consults on any Hospital patient; schedule any surgical procedure (including emergencies), endoscopies, etc.; read Cardiovascular Services reports until their records are completed.

The suspended physician must notify the Medical Staff Office who will care for his patients.

The Medical Staff Coordinator will notify the Director of Health Information Services which physicians were suspended. The Director will notify Hospital personnel of all the suspended physicians in order to enforce the suspension.

3.11.7 It is the Practitioner's responsibility to notify the Medical Staff Office of any extenuating circumstances (*e.g.,* vacation of more than two (2) weeks, illness, *etc.*) which may interfere with the timely completion of medical records. Notification should occur prior to the absence and such days will not be accrued toward delinquent chart days.

3.11.8 Any Practitioner who feels that an error has been made in the determination of his/her delinquent chart status may be given the opportunity to appeal in writing to the President of the Medical Staff before 8:00 a.m. on the morning of the Medical Executive Committee meeting. As provided in Bylaws Section X(A)(7), automatics suspension do not give rise to any fair hearing or appellate procedures as provided in the Bylaws; the appeal provided under this subsection is an informal process.

3.12 Filing of Incomplete Records

In the event a medical record remains incomplete because the attending Practitioner is no longer available to complete, or is no longer capable of completing, the record (*e.g.,* due to

death, disability, *etc.*), it shall be the responsibility of the MEC to declare the record closed and to authorize the medical record to be filed. The MEC may not write in the record further than to declare it closed. The MEC shall not be responsible for any action other than preserving the record as it was left by the attending Practitioner. Notification of incomplete medical records shall be provided to the MEC by Health Information Services

3.13 Removal of Medical Records/Release of Medical Information

All records are the property of the Hospital. Removal of medical records and release of information contained in medical records shall be in accordance with applicable law (*e.g.,* court order, patient authorization, *etc.*) and the procedure set forth in applicable Hospital policies, as such policies may be amended from time to time. Records include but are not

limited to echocardiographs, ECG's, holter monitor, EEG's, pacemaker and/or vascular studies.

3.14 Respiratory Therapy

In all cases the responsible Practitioner must place in the patient's medical record, the timely, pertinent clinical evaluation of the progress of the patient as a result of the respiratory therapy.

3.15 Medical Record Documentation

Anyone providing care to a patient shall document such care, in a timely, accurate, and legible manner, in the patient's medical record within the scope of his/her authority (*e.g.,* as permitted by his/her licensure, Privilege set, job description, *etc.*) and consistent with Hospital/Medical Staff Policies, Department guidelines, and applicable law.

3.16 Notice of Privacy Practices

All Practitioners are required to abide by the terms of the Hospital's Notice of Privacy Practices prepared and distributed to patients as required by the Federal patient privacy regulations.

ARTICLE IV. CONSENT AND CONSULTATION

4.1 Surgical Consent

No surgical procedure shall be performed without the written consent of the patient or his/her legal representative in case the patient is a minor, incompetent, or otherwise unable to act for him/herself. An exception may be made in case of emergency where the life or well-being of the patient might be jeopardized by delaying treatment. In emergency cases where consent cannot be obtained, consultation with two (2) qualified Physicians is recommended.

4.2 Informed Consent

Informed consent shall be obtained in accordance with the Hospital's informed consent policy; as such policy may be amended from time to time. Informed consent documents for a surgical procedure should provide information relative to: who specifically will perform the procedure, what the procedure is, provision for anesthesia as required, and disposal of any tissue removed in the course of the procedure.

4.3 Consultation

In the event of consultation pursuant to Section 1.5, the consultant must include a statement of the conclusions or impressions and a statement on the course of action planned for the patient for this episode of care.

ARTICLE V. TERMINATION OF LIFE SUSTAINING TREATMENT/DISCONTINUATION OF LIFE SUPPORT

5.1 Practitioners will follow the Hospital policy and guidelines regarding termination of life sustaining treatment as such Hospital policy and guidelines may be amended from time to time.

ARTICLE VI. DUTY ROSTER

6.1 Duty Roster

6.1.1 The duty roster for the care of patients without a Practitioner shall be the responsibility of the Department concerned.

6.1.2 All Appointees shall participate in the applicable duty roster for the care of patients without a Practitioner as assigned by the Practitioner's Department rules.

ARTICLE VII. ALTERNATE COVERAGE

7.1 Alternate Coverage

In choosing alternate coverage, a Practitioner must designate another Practitioner who is a Medical Staff Appointee with Privileges in the commensurate specialty/subspecialty.

ARTICLE VIII. AUTOPSIES

8.1 Autopsies

The Medical Staff attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest. The Medical Staff (and specifically the attending Practitioner) shall be informed of autopsies that the Hospital intends to perform. No autopsy shall be performed without a written consent signed in accordance with Ohio law.

All Hospital autopsies shall be performed by a Hospital pathologist or by a Physician delegated this responsibility.

ARTICLE IX. DISASTER PLAN

9.1 Disaster Plan

9.1.1 In the event the Hospital's Emergency Management Plan ("Plan") is implemented, all Practitioners with a Medical Staff appointment and/or Privileges at the Hospital shall accept the duties and responsibilities as outlined in the Plan, as such Plan may be amended from time to time.

9.1.2 As part of this responsibility the Medical Staff will oversee the performance of non-Medical Staff volunteer Practitioners who are granted disaster Privileges by direct observation, mentoring, or medical record review as appropriate.

ARTICLE X. EMERGENCY DEPARTMENT ON CALL ROSTER

10.1 Emergency Department On Call Roster

10.1.1 The President of the Medical Staff or designee shall notify each Practitioner before his/her coverage period as to when he/she is on call in the Emergency Department.

10.1.2 Refusal to provide care for an Emergency Department patient who, in the opinion of the Emergency Department Physician may need admission, while a Practitioner is on-call and after verification of the alleged incident by the Practitioner's Department Chair is grounds for corrective action against the Practitioner who failed to respond.

10.1.3 In the event the assigned on-call Practitioner signs out to another Practitioner, the originally designated Practitioner will ultimately be held responsible for call coverage.

10.1.4 The Medical Staff Office and Emergency Department must be notified of any changes or substitutions to the on-call schedule.

10.1.5 No Practitioner over the age of sixty (60) shall be obligated to take call in the Emergency Department**.** If the Department involved so deems, this age limit may be changed.

10.1.6 The Practitioner on call is obliged to attend a patient when requested by the Emergency Department Physician. If, under unusual circumstances, the Practitioner on first call is unable to attend the patient, it is his/her responsibility to refer the case to the second Practitioner on call or obtain suitable coverage.

ARTICLE XI. EMERGENCY DEPARTMENT RESPONSE TIME

11.1 Emergency Department Response Time

11.1.1 Practitioners are expected to respond to calls from the Emergency Department within thirty (30) minutes. The Emergency Department will call the Practitioner at fifteen (15) minute intervals.

11.1.2 If the attending and/or alternate or the on-call Practitioner does not call back within sixty (60) minutes, the Department Chair will be notified. The Emergency Department will call the practitioner at fifteen (15) intervals.

If the on-call practitioner for Medicine/Family Practice does not call back within sixty (60) minutes, the Hospitalist will be called for orders/direction/admission. The patient will remain in the care of the admitting physician until discharge or transfer of care with mutual physician agreement.

11.1.3 Failure to respond to the Emergency Department within the sixty (60) minute timeframe, after verification of the alleged incident by the Practitioner's Department Chair, is grounds for corrective action.

ARTICLE XII. INPATIENT RESPONSE TIME

11.1 Inpatient Response Time

11.1.1 Practitioners caring for patients are expected to respond to calls from the inpatient nursing units and other Hospital departments (including Case Management) within 30 minutes. If a Practitioner does not respond within 30 minutes, a second call will be made to the Practitioner. If there is no response to the 2nd call after 30 minutes (60 minutes from the first call), the appropriate staff member will contact the Hospitalist for orders/direction (*e.g.* pain medications, diet orders, admission orders, discharge orders, lab results, *etc.*)

11.1.2 Patient issues that are not or cannot be resolved by the Hospitalist, will be referred to the Department Chair.

11.1.3 Failure to return calls within the allotted time frame, if validated by the Department Chair, may result in corrective action.

ARTICLE XIII. RESIDENTIAL REQUIREMENT

13.1 Residential Requirement

Practitioners with Privileges at the Hospital shall live within sufficiently close proximity to the Hospital to enable him/her to provide continuous care to his/her patients, or make arrangements that are satisfactory to the MEC for alternative coverage for his/her patients from a Practitioner(s) with comparable Privileges.

ARTICLE XIV. ANESTHESIA SERVICES

14.1 Anesthesia Services

14.1.1 "Anesthesia" involves the administration of a medication to produce a blunting or loss of pain perception (analgesia); voluntary and involuntary movements; autonomic function; and memory and/or consciousness, depending on where along the central neuraxial (brain and spinal cord) the medication is delivered.

14.1.2 "Analgesia" involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail.

14.1.3 The criteria for determining the anesthesia service Privileges to be granted to a Practitioner or AHP, and the procedure for applying the criteria to Practitioners or AHPs requesting Privileges for any type of anesthesia services, including those not subject to the anesthesia administration/supervision requirements pursuant to the Medicare Hospital Condition of Participation for Anesthesia Services, shall be generally set forth in the Medical Staff Bylaws and AHP Policy and detailed in applicable Hospital/Medical Staff Policies, and Privilege sets.

ARTICLE XV. PRACTITIONER CONFLICTS/COMPLAINTS

15.1 In an effort to promote collaboration and facilitate problem solving, and to prevent conflicts from interfering with the process of care delivery, a complaint handling/conflict resolution process will be followed for concerns/complaints regarding Practitioners.

15.2 A concern/complaint regarding Practitioner behavior should be reported within forty-eight (48) business hours of occurrence or identification of the problem. Reporting shall be done by documenting the concern/complaint on a Medical Staff Anecdotal Record Form which is available in the Medical Staff Office or on the Hospital's Intranet site. The report should specify the facts supporting the complaint and may be made anonymously. If the complainant is a Hospital employee, he/she should apprise his/her department director of the concern and intent to report. The department director may advise on the appropriateness of an intent to report or whether an alternate process should be used (i.e. for clinical/technical quality problem). After this review, and if the department director agrees that the concern/complaint is of an appropriate nature to warrant further consideration, the completed Medical Staff Anecdotal Record Form will be sealed in a confidential envelope and forwarded to the Medical Staff Office which will document receipt of the complaint and forward it to the appropriate Department Chair for necessary action. If the complaint involves the Department Chair or other Medical Staff leader, the report will be forwarded to the Medical Staff President directly. If the complaint involves the Medical Staff President, the report will be forwarded to the Hospital CEO directly. The Medical Staff Coordinator will facilitate this process.

15.3 Upon receipt of a complaint, the Department Chair (or Medical Staff President/Hospital CEO, as appropriate) shall take one of the following actions:

15.3.1 Refer the matter for follow up in accordance with the Disruptive Practitioner Policy if the conduct of the identified Practitioner embodies any of the criteria set forth in such Policy.

15.3.2 Refer the matter for follow up in accordance with the Practitioner Effectiveness Policy if the conduct of the identified Practitioner embodies any of the criteria set forth in such Policy.

15.3.3 Counsel the Practitioner regarding the behavior, or initiate a collaborative problem solving process to include the complainant (provided he/she does not wish to remain anonymous) and/or his/her department director or line administrator consistent with the collegial intervention process set forth in the Medical Staff Bylaws or AHP Policy, as applicable.

15.3.4 Refer the matter to the MEC if the conduct of the identified Practitioner embodies any of the criteria for initiation of corrective action outlined in the Medical Staff Bylaws or pursuant to the AHP Policy, as applicable.

15.4 Documentation of counseling or problem resolution under these circumstances shall be forwarded to the Medical Staff Office and maintained in the Practitioner's credentials file.

15.5 The complainant (if known) and/or his/her director or line administrator shall be advised that follow up action has been taken but shall not be provided with specific details of the resolution or copies of documentation related thereto.

15.6 The time limits set forth in this Policy can be extended if extenuating circumstances prevent adherence to them.

15.7 For purposes of this Policy, the term "Practitioner" shall include Allied Health Professionals with Privileges at the Hospital.

ARTICLE XVI. DISRUPTIVE PRACTITIONER POLICY AND MEDICAL STAFF CODE OF CONDUCT

16.1 Statement of Purpose

16.1.1 This Disruptive Practitioner Policy and the Medical Staff Code of Conduct (attached hereto as Exhibit A) outlines expectations of conduct of all Practitioners working in the Hospital, examples of conduct that fail to meet those expectations (inappropriate conduct), and procedures to be used by Medical Staff leadership in dealing with Practitioners whose conduct fails to meet those expectations.

16.1.2 This Policy also addresses sexual harassment of employees, patients, other Practitioners, and individuals, which will not be tolerated.

16.1.3 In dealing with incidents of inappropriate conduct, the protection of patients, employees, Practitioners, and others in the Hospital, and the maintenance of orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with State and Federal law and providing an environment free from sexual harassment are also critical.

16.1.4 Whenever possible, the goal of Medical Staff leadership in addressing inappropriate conduct is educational and collegial, rather than punitive, with the intent of inducing voluntary, responsive actions by the Practitioner to resolve the concerns that have been identified, and thus avoid the necessity of proceeding with corrective action under §7.2 of the Bylaws or AHP Policy, as applicable.

16.1.5 Nothing in this Policy shall be construed as obligating the Board (through the CEO as its administrative agent) or Medical Staff leadership to follow this Policy prior to implementing formal corrective action on the basis of a single incident of disruptive behavior.

16.1.6 For purposes of this Policy, the term "Practitioner" shall include Allied Health Professionals with Privileges to practice at the Hospital.

16.2 Definition and Examples of Inappropriate Conduct

All Practitioners practicing in the Hospital must treat others with respect, courtesy, and dignity, and conduct themselves in a professional and cooperative manner. Practitioners must faithfully attend to patient care responsibilities and cooperate with other Practitioners and Hospital personnel attending to patient care responsibilities. Practitioners must respect Hospital property and the property rights of others. Practitioners who conduct themselves otherwise are engaging in inappropriate conduct.

To aid in both the collegial education of Practitioners and in the enforcement of this Policy and the Code of Conduct, examples of inappropriate conduct include, but are not limited to:

16.2.1 threatening or abusive language directed at patients, visitors, Hospital personnel, or other Practitioners. (e.g. belittling, berating, and/or threatening another individual);

16.2.2 degrading or demeaning comments regarding patients, families, Hospital personnel, other Practitioners, or the Hospital;

16.2.3 profanity or similarly offensive language while in the Hospital or while speaking with Hospital personnel;

16.2.4 inappropriate physical contact with another individual that is threatening or intimidating;

16.2.5 derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual or comments otherwise critical of the

Hospital, another Practitioner, or any other individual that are made outside of appropriate Medical Staff and/or administrative channels;

16.2.6 inappropriate medical record entries, concerning the quality of care being provided by the Hospital or any other individual or otherwise critical of the Hospital, or other Practitioners or Hospital personnel;

16.2.7 deliberate falsification or unauthorized alteration of medical records;

16.2.8 unauthorized possession, use, copying, reading, or disclosure of confidential patient information;

16.2.9 deliberate destruction or defacement of Hospital property or the property of a Hospital employee, patient, visitor, or another Practitioner;

16.2.10 unauthorized possession, use, or distribution of alcohol or drugs on Hospital premises, or attending to patients while under the influence of drugs or alcohol;

16.2.11 possession or concealment of firearms, weapons, or explosives on Hospital premises;

16.2.12 disruptive behavior which disturbs a patient or visitor, or impairs Hospital personnel or another Practitioner in performance of his/her duties;

16.2.13 unwillingness to work cooperatively and harmoniously with other Practitioners and Hospital personnel, including, but not limited to, refusal to cooperate with the Hospital's peer review process and the Hospital's utilization review process;

16.2.14 refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Medical Staff and Department rules and regulations, including, but not limited to, emergency call requirements, response times, medical record keeping, and other patient care responsibilities;

16.2.15 "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

16.2.15.1 Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

16.2.15.2 Visual/Non-Verbal: derogatory posters, cartoons, or drawings, suggestive objects or pictures, leering, and/or obscene gestures;

16.2.15.3 Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

16.2.15.4 Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

16.3 Reporting Inappropriate Conduct and Follow Up Action

16.3.1 Issues of inappropriate conduct by Practitioners will be addressed in accordance with this Policy.

16.3.2 Medical Staff leadership may request the assistance of Administration in addressing concerns of inappropriate Practitioner behavior. If the report involves inappropriate behavior directed toward Hospital staff, Administration shall be consulted. If the report involves a Practitioner employed by the Hospital, Medical Staff leadership and Administration shall consult with each other regarding the appropriate course of action. If the report involves a supervisor or Medical Staff leader, Administration shall be notified.

16.3.3 All concerns of inappropriate Practitioner conduct shall be documented in writing in accordance with the process set forth in §4.2.

16.3.4 Documentation of inappropriate conduct is critical since it may not be one (1) incident that justifies corrective action, but rather a pattern of conduct. Accordingly, the written report should include the following information, to the extent available:

16.3.4.1 The date and time of the inappropriate behavior

16.3.4.2 The name of the patient, staff, or Practitioners involved, if the behavior affected or involved a patient, staff, or other Practitioners.

16.3.4.3 The circumstances that precipitated the situation

16.3.4.4 A description of the inappropriate behavior limited to factual, objective language.

16.3.4.5 The consequences, if any, of the inappropriate behavior to patient care or Hospital operations.

16.3.4.6 Any action taken to remedy the inappropriate behavior at the time of its occurrence, including the date, time, place, action taken, and name(s) of those intervening.

16.3.5 Upon receipt of a complaint of inappropriate Practitioner conduct subject to this Policy, the matter shall either be addressed pursuant to (g) below; or, the Medical Staff Wellness Committee shall be convened to inquire into the incident.

16.3.6 Following such review as deemed appropriate by the Wellness Committee, the complaint shall be resolved through collegial intervention or referred directly to the

MEC for consideration of corrective action pursuant to the applicable provisions set forth in the Medical Staff Bylaws or Allied Health Professional Policy, as applicable.

16.4 Sexual Harassment Concerns

16.4.1 Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the actions set forth in this section.

16.4.2 A meeting shall be held between the Practitioner implicated in the incident and Medical Staff leader(s) to discuss the incident. If the Practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the Department Chair shall send a letter to the Practitioner documenting the meeting and concerns. A copy of the letter shall be placed in the Practitioner's confidential credentials file. This letter shall also set forth those additional actions, if any, that result from the meeting.

16.4.3 If the Practitioner refuses to agree to stop the conduct immediately, this refusal shall result in the matter being referred to the Medical Executive Committee for consideration of corrective action under Article 7.2 of the Bylaws, or AHP Policy, as applicable.

16.4.4 Any reports of retaliation or any further reports of sexual harassment, after the Practitioner has agreed to stop the inappropriate conduct, shall result in an immediate inquiry by a Medical Staff leader(s). If the inquiry results in a finding that further inappropriate conduct took place, the matter shall be referred to the Medical Executive Committee for consideration for corrective action, under Article 7.2 of the Bylaws, or AHP Policy, as applicable.

16.4.5 A single, incident of sexual harassment may result in referral to the Medical Executive Committee for consideration for corrective action under Article 7.2 of the Bylaws, or AHP Policy, as applicable. A determination to refer a single incident to the Medical Executive Committee for corrective action is at the discretion of either the Medical Staff leaders, the Hospital Administrator or the chair of the Board.

16.5 Miscellaneous

16.5.1 In order to effectuate the objectives of this Policy, and except as may otherwise be determined by the Medical Executive Committee, the Practitioner's counsel shall not attend any of the meetings described above.

16.5.2 The Medical Staff leadership and Hospital Administration shall provide orientation and education to make employees, Members, and other Hospital personnel aware of this Policy and Code of Conduct, prohibiting sexual harassment, and requiring respectful, dignified conduct.

16.5.3 The Medical Staff leadership and Hospital Administration shall institute procedures to facilitate prompt reporting of conduct that may violate this Policy and Code of Conduct and prompt action as appropriate under the circumstances.

16.5.4 If, at any time, Medical Staff leadership or Hospital Administration reasonably believe that the inappropriate behavior of a Practitioner may be related to health or impairment concerns, the Practitioner may be requested to submit to a physical or mental examination. Upon receipt of the examination report, a decision will be made as to whether the matter should be handled pursuant to this Policy or the Medical Staff Impaired Practitioner Policy.

16.5.5 No individual who, in good faith, reports disruptive behavior or who otherwise participates in the procedure set forth herein, shall be retaliated against for such report or participation.

16.5.6 The individual who filed the report (if known) shall be advised that follow up action has been taken but shall not be provided with specific details of the resolution.

16.5.7 All letters, reports, minutes, or other writings or communications submitted or generated pursuant to this Policy shall be maintained in the applicable Practitioner's credentials file and treated as confidential peer review documents to the full extent permitted by law. The identity of individuals providing information pursuant to this Policy, whether in writing or verbally, shall be maintained as confidential peer review information to the full extent permitted by law. It is the intent of the Hospital and its Medical Staff that all individuals who participate in the process set forth in this Policy, including those who provide information, shall be deemed to be engaged in a peer review activity and entitled to immunity to the full extent permitted by law. All individuals involved with the procedure set forth herein shall maintain the confidentiality of the information related thereto and shall not discuss the matter with anyone other than as needed to fulfill his/her obligations under this Policy.

16.5.8 The Credentials Committee and MEC shall be advised, upon request, of any incidents resolved pursuant to this Policy, or currently pending, as part of the credentialing information needed to make recommendations regarding Medical Staff reappointment or for a re-grant of Privileges, and for the purpose of evaluating, maintaining, and monitoring the quality of healthcare services provided by Practitioners at the Hospital.

16.5.9 For purposes of this Policy, the Medical Staff, through its committees, shall be responsible for evaluating, maintaining, and monitoring the quality and utilization of health care services at the Hospital. Inappropriate Practitioner behavior is a quality of care issue subject to report to, without limitation, the MEC. In carrying out his/her duties under this Policy, whether as a committee chair/member, Medical Staff officer, or otherwise, each Medical Staff Appointee shall be acting in his/her capacity as a peer review committee member and designated agent of the MEC. Additionally, such peer review committees and their designated agents may, from

time to time and/or as specifically provided herein, appoint the CEO or other members of Hospital Administration as their agent in carrying out such peer review duties.

16.5.10 Education for the Medical Staff and other healthcare professionals shall be provided regarding this Policy and the Medical Staff Code of Conduct as needed.

ARTICLE XVII: IMPAIRED PRACTITIONER POLICY

17.1 Introduction

Pursuant to the Medical Staff Bylaws, a Medical Staff Wellness Committee ("Committee") shall be established to investigate reports of suspected Practitioner physical or mental impairment, to make recommendations for treatment, and/or to make recommendations for corrective action, as appropriate to the situation. The Committee shall act pursuant to this Impaired Practitioner Policy ("Policy").

17.1.1 This Policy is being implemented to provide general guidelines for dealing with Practitioners who suffer from a physical or mental impairment that affects their ability to exercise the Clinical Privileges granted to them and/or to otherwise function at the Hospital. The intent of the Policy is to provide a mechanism to address impairment in a manner that is separate from the core Medical Staff corrective action functions. The purposes of the Policy are to: provide the Medical Staff a vehicle by which impaired Practitioners may be identified and assisted by their peers and colleagues; encourage self-referral by an impaired Practitioner and referral by other Practitioners and Hospital staff; maintain the confidentiality of the Practitioner seeking referral or referred for assistance; help the Practitioner recover from the impairment; protect the patients of the affected Practitioner; protect the integrity and credibility of the Hospital; assist the Hospital in meeting its obligations to its patients, other Practitioners and Hospital personnel; and, educate the Hospital and Medical staffs regarding Practitioner health issues.

17.1.2 Nothing in this Policy should be construed as requiring that a Practitioner be evaluated by the Committee prior to any action which might otherwise be taken pursuant to the Medical Staff Bylaws or Allied Health Professional Policy, as applicable, including the initiation of corrective action proceedings.

17.1.3 This Policy does not preclude any person authorized to impose a summary suspension pursuant to the Medical Staff Bylaws from imposing such suspension because the affected Practitioner is being investigated by or cooperating with the Committee, nor does this Policy preclude an authorized individual from summarily suspending a Practitioner pursuant to the Medical Staff Bylaws or Allied Health Professional Policy, as applicable, based upon information which the authorized individual learns as a result of being a member of the Committee. The individual imposing such suspension shall not be precluded from continuing as a member of the Committee with respect to the Practitioner in question.

17.1.4 Terms used in this Policy shall have the same meaning as set forth in the Medical Staff Bylaws unless a different definition is provided in this Policy. For purposes of this Policy, the term "Practitioner" shall include Allied Health Professionals with Privileges at the Hospital.

17.2 Composition of Committee

The Committee shall be an *ad hoc* committee of the Medical Staff and shall be composed of those members set forth in the Bylaws. In the event that a given Committee member is the Practitioner who is the subject of the report, another Practitioner shall be appointed by the Committee to participate in review of the matter, and the Committee member who is the subject of the report shall not participate in the Committee proceedings as a Committee member.

17.3 Duties of Committee

17.3.1 The Committee shall review and investigate reports referred to it related to the health, well-being, or impairment of Practitioners and shall take such actions as are authorized pursuant to this Policy.

17.3.2 The Committee may also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the MEC, may develop education programs or related activities for the Hospital and Medical staffs about illness and impairment recognition issues specific to Practitioners. Such educational programs and materials will include information to assist Practitioners in self-referring for treatment.

17.3.3 The Committee shall report to the MEC on an as needed basis. The Credentials Committee shall query the Committee with respect to a Practitioner's reappointment and/or re-grant of Privileges. Upon request, the Committee shall provide written reports addressing all ongoing situations under the oversight of the Committee; provided, however, that such reports shall not include past situations such as those for which treatment has been completed. Reports shall include:

17.3.3.1 Whether the Practitioner is presently being investigated by the Committee for impairment problems.

17.3.3.2 Whether the Practitioner has been requested to seek treatment or consultation for impairment problems, or whether the Practitioner has self-referred for treatment.

17.3.3.3 Whether the Practitioner has been referred to the MEC for corrective action.

17.3.3.4 If the Committee has made recommendations to the Practitioner, the status of the Practitioner's compliance with such recommendations.

17.3.3.5 Whether the Practitioner is providing unsafe treatment to patients.

17.3.3.6 Whether a Practitioner is being or should be monitored to assess the Practitioner's ability to provide continued safe patient care during rehabilitation or during a corrective action process.

17.3.4 If the Committee believes corrective action to be warranted, the Committee shall make such recommendation to the MEC consistent with this Policy and the applicable provisions set forth in the Medical Staff Bylaws or Allied Health Professional Policy.

17.4 Meetings

The Committee shall meet as needed at the discretion of the Committee chair, and shall maintain minutes of its meetings. Any records maintained by the Committee in connection with reports that are determined to be without merit shall be kept in a sealed file on behalf of the Committee by the Medical Staff Office and retained consistent with the Hospital's record retention and destruction policy. Records generated by the Committee in connection with reports that are determined to have merit shall be maintained by the Committee chair when the Committee is active and sealed and retained on behalf of the Committee by the Medical Staff Office when the Committee has concluded its work.

17.5 Confidentiality and Immunity

17.5.1 All letters, reports, minutes, or other writings submitted to or generated by the Committee shall be treated as confidential peer review documents to the full extent permitted by law.

17.5.2 The identity of individuals providing information to the Committee and all information provided by such individual, whether written or oral, shall be maintained as confidential peer review information to the full extent permitted by law.

17.5.3 Confidentiality as to the identity of the Practitioner involved shall be maintained in all reports by means of a numerical code. Access to the numerical code number shall be provided only to those individuals who are required to have such information.

17.5.4 It is the intent of the Hospital and the Medical Staff that the members of the Committee and all individuals providing information to the Committee shall be deemed to be engaged in a peer review activity and are entitled to immunity to the full extent permitted by law.

17.6 Investigation

17.6.1 If an individual has a good faith belief that a Practitioner may be impaired, the individual should document his/her concern in writing.

17.6.2 The appropriate Medical Staff leader(s) shall review the written report and, if appropriate, discuss it with the individual who submitted the report to verify the credibility and legitimacy of the complaint.

17.6.3 In the event investigation is warranted, the Committee shall be convened.

17.6.4 The Committee shall respond to the individual(s) who reported the suspected impairment by confirming receipt of the complaint. All individuals making a report or otherwise engaged in the investigation of such report shall act appropriately and in a confidential manner and shall avoid speculation, conclusions and gossip. All conversations regarding the matter shall be limited to those individuals who have a need to know. The individual making a report shall be advised when follow up action has been taken but shall not be provided specific details of the resolution. No individual who, in good faith, reports suspected impairment or who otherwise participates in the procedure set forth herein shall be retaliated against for such report or participation.

17.6.5 In conducting the investigation, the Committee may contact Department Chairs, other Practitioners, and Hospital personnel, as necessary, in order to properly prepare a report with respect to the Practitioner's physical or mental condition and how such condition, if any, is affecting patient care, the Practitioner's relationships with other individuals, or such other matters as the Committee deems relevant. The Committee may also conduct an interview with the Practitioner if the Committee believes such an interview to be appropriate to the situation. Such investigation shall be conducted as confidentially and as discreetly as is possible under the circumstances.

17.6.6 Upon completion of the investigation, the Committee shall prepare a written report setting forth its findings as to whether the Practitioner has an impairment; and, if so, making recommendations as to what action(s) should be taken. The Committee shall send a copy of the written report and its recommendations to the MEC.

17.7 Committee Action

17.7.1 If the Committee concludes that there is reason to believe that the Practitioner is impaired, the Committee has the authority to take any or all of the following actions:

17.7.1.1 Recommend that the Practitioner submit to a physical and/or mental examination, at the Practitioner's expense, by a Physician or other qualified individual chosen by the Committee who shall submit a report to the Committee containing, at a minimum, the following information:

(a) Whether the Practitioner is suffering from an impairment.

(b) The nature and scope of the impairment.

(c) Whether such impairment is treatable and, if so, recommendations as to the proper course of treatment.

(d) The Practitioner's present ability to continue to practice within the Hospital.

(e) Whether any limitations should be placed on the Practitioner with respect to his or her practice.

In the event a second opinion is requested by the Committee, such subsequent evaluation shall be at the Hospital's expense.

17.7.1.2 Recommend to a Practitioner believed to be suffering from an alcohol or drug related impairment that he or she undertake rehabilitation through an approved treatment provider[1] and, if appropriate, that such be reported to the State Medical Board or other appropriate licensing agency.

17.7.1.3 Recommend that the Practitioner seek counseling.

17.7.1.4 Recommend that the Practitioner request a leave of absence pursuant to the Medical Staff Bylaws or Allied Health Professional Policy, as applicable.

17.7.1.5 Recommend to the MEC that corrective action be initiated against the Practitioner pursuant to the applicable provisions of the Medical Staff Bylaws or Allied Health Professional Policy, as applicable.

17.7.1.6 Recommend that the Practitioner be permitted to continue treating patients but that such treatment be monitored for continual assessment of the Practitioner's ability to provide safe patient care through rehabilitation or any corrective action process.

17.7.1.7 Take any other action consistent with the purposes of this Policy and the Medical Staff Bylaws or AHP Policy, as applicable.

Unless corrective action is recommended, the Committee shall not be required to obtain the approval of the MEC with respect to any arrangements agreed to by the Committee and the Practitioner.

If the Committee concludes that there is no reason to believe that the Practitioner is impaired, the initial letter submitted to the Committee, the Committee's report and recommendation (if any), and all other documentation compiled by the Committee as part of its investigation shall be maintained on behalf of the Committee by the Medical Staff Office as confidential peer review documents in accordance with the Hospital’s record

[1] An approved treatment provider shall be one recognized and approved by the Ohio State Medical Board. If such a provider does not exist, then it shall be a provider chosen by the Committee.

retention and destruction policy. The finding of the Committee shall be documented in the Committee minutes, which shall be kept in a sealed file by the Medical Staff Office.

If the Committee concludes that there may be merit to the report but that the facts are insufficient to warrant immediate action, the Committee chair shall maintain the complete file, and the Practitioner's activities and practice will be monitored until it can be established that there is, or is not, a reasonable belief that an impairment exists.

17.8 General Guidelines with Respect to Treatment

17.8.1 The Committee shall encourage rehabilitation when appropriate and shall assist the affected Practitioner in locating a rehabilitation program or properly qualified individual to treat the affected Practitioner. The Practitioner shall be financially responsible for the costs of his or her rehabilitation/treatment.

17.8.2 Clinical Privileges

17.8.2.1 If an affected Practitioner's Clinical Privileges have not been the subject of corrective action, the Practitioner must apply for a leave of absence in the following circumstances:

17.8.2.2 If the Practitioner agrees to participate in an approved inpatient rehabilitation program.

17.8.2.3 If the Practitioner's treating Physician or other treatment provider recommends that the Practitioner not treat patients for a period of time while undergoing treatment.

17.8.2.4 The fact that a treating Physician or other treatment provider has opined that the affected Practitioner may continue to treat patients while undergoing treatment shall not preclude the Committee from recommending to the MEC that corrective action be taken limiting such Practitioner's Privileges.

17.8.3 Records/Reports from Treatment Provider

17.8.3.1 If an affected Practitioner participates in a rehabilitation program or otherwise undergoes treatment with respect to his or her impairment, the Practitioner shall agree to execute all necessary releases and authorizations for the release of information, so that reports and records from the treatment provider can be submitted to the Committee. Such records/reports shall include, at a minimum, the following information:

17.8.3.2 Whether the Practitioner is participating in a program or other course of treatment and, if so, the nature of the program or course of treatment.

17.8.3.3 Whether the Practitioner has complied with the terms of the program or other course of treatment.

17.8.3.4 If applicable, whether the Practitioner attends Alcoholics Anonymous meetings or other similar meetings regularly.

17.8.3.5 Whether monitoring of the Practitioner's behavior and conduct is necessary and, if so, recommendations with respect to such monitoring.

17.8.3.6 Whether, in the opinion of the treatment provider, the Practitioner has been rehabilitated or has otherwise recovered from the mental or physical impairment.

17.8.3.7 Whether, in the opinion of the treatment provider, the Practitioner is in need of additional treatment and, if so, the scope of such treatment.

17.8.3.8 Whether, in the opinion of the treatment provider, the Practitioner is capable of providing continuous competent care to his or her patients and of resuming his or her practice within the Hospital.

17.8.3.9 A complete, true and accurate copy of all of the treatment provider’s records and/or aftercare contracts related to the Practitioner.

17.8.3.10 The fact that a treatment provider submits information favorable to the Practitioner shall not preclude the Committee from obtaining a second opinion if the Committee believes such opinion necessary; nor, shall it preclude the MEC from obtaining such an opinion prior to reinstating such Practitioner's Clinical Privileges. The Committee shall be solely responsible for selecting a Practitioner to provide a second opinion, and the costs associated with obtaining such second opinion shall be borne by the Hospital.

17.8.4 Reinstatement of Clinical Privileges

17.8.4.1 Upon completion of a rehabilitation program or such other treatment as is necessary with respect to the impairment at issue, the Practitioner must request, in writing, termination of the leave of absence and/or reinstatement of his or her Clinical Privileges, as appropriate, pursuant to the Medical Staff Bylaws or Allied Health Professional Policy, as applicable. Such request shall be forwarded to the Committee which may require that the Practitioner agree to any or all of the following requirements as a condition of termination of the leave of absence and/or to reinstatement of Clinical Privileges:

(a) Provide the Committee with the name of one or more Medical Staff Appointees with comparable Privileges who are willing to assume responsibility for the care of the Practitioner's patients in the event the Practitioner is unable or unavailable to care for them.

(b) Agree to attend weekly recovery meetings (*e.g.,* Alcoholics Anonymous, Narcotics Anonymous, *etc*.), at which the Practitioner's attendance is recorded, and to submit a written record of such attendance to the Committee on a monthly basis.

(c) Agree, at the request of the Committee, to submit to random blood and/or urine testing with the results of such testing to be submitted to the Committee. The cost of such testing shall be borne by the Practitioner. The Committee shall determine the method by which the specimen is to be collected and the manner in which the testing is to be done. If the specimens for such testing are not submitted in accordance with the Committee's time requirements, the Practitioner's Clinical Privileges shall be automatically suspended until compliance has been established to the satisfaction of the Committee.

(d) Agree to other monitoring requirements as are deemed appropriate by the Committee.

(e) Agree to execute any and all releases or authorizations necessary to insure that information is provided to the Committee.

(f) Provide the Committee with copies of any and all aftercare contracts between the Practitioner and the treatment provider.

(g) Execute a contract between the Practitioner and the Hospital setting forth the monitoring process, which shall be adhered to by the Practitioner and the Committee.

17.9 Refusing Committee Recommendation

If the Committee determines that there is a reasonable basis for believing that the affected Practitioner is impaired, and if the Committee has recommended a course of treatment but the affected Practitioner has refused to accept the Committee's recommendation or to otherwise comply with the requirements of this Policy, such refusal shall be immediately reported by the Committee to the MEC, CEO, and, if required, to the Ohio State Medical Board or other appropriate licensing agency.

17.10 Reporting Requirements

The CEO shall be notified prior to any reporting that is required by state and federal law of actions taken with regard to an impaired Practitioner or information related to an impaired Practitioner. Any reports of criminal activity required under state or federal law shall be reported immediately to the CEO for reporting to the appropriate authorities.

ARTICLE XVIII: FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) AND ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) POLICY

18.1 Purpose

To define the process by which the Medical Staff monitors, evaluates, and reports quality of patient care provided by Practitioners and Allied Health Professionals to identify opportunities for improvement, improve performance and outcomes of care on an individual and organization-wide basis, and take appropriate corrective action when necessary. For purposes of this Policy, the term "Practitioner" shall include Allied Health Professionals with Privileges at the Hospital.

18.2 Authority and Responsibility

The Medical Staff and Board have the authority and responsibility to monitor and evaluate the quality of patient care through organizational and Medical Staff quality improvement activities. The Medical Staff has a leadership role in organizational improvement activities designed to ensure that the findings of the assessment process are relevant to a Practitioner's performance. The Medical Staff is responsible for determining the use of information from ongoing and focused professional practice evaluation process on a Practitioner's granted Clinical Privileges. The Medical Executive Committee will monitor the overall professional practice evaluation quality process.

18.3 Definitions

18.3.1 Focused Professional Practice Evaluation (FPPE):

The process whereby the Hospital/Medical Staff evaluate the Privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested Privilege at the Hospital.

This process may also be used when a question arises regarding a currently privileged Practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the Hospital/Medical Staff evaluate and determine the Practitioner's professional performance.

18.3.2 Ongoing Professional Practice Evaluation (OPPE):

Periodic performance review will be conducted at least every eight (8) months for all current Practitioner's with Privileges utilizing established performance indicators. Professional practice trends that impact the quality of care and patient safety may require intervention by the Medical Staff.

18.3.3 Focused Professional Practice Evaluation (FPPE) – New Privileges

18.3.3.1 A period of focused review will be conducted for all newly appointed Practitioners and all existing Practitioners who have been granted NEW Privileges.

18.3.3.2 The FPPE plan will be Practitioner specific. The plan will include the general elements described in the OPPE as well as specific indicators as determined by the Department Chair and any special medical Privilege criteria for those Privileges which he/she has been granted.

18.3.3.3 One or more of the following elements will be utilized for each Privilege:

(1) Mortalities
(2) Complications
(3) Readmissions
(4) Quality of documentation
(5) Returns to the Operating Room
(6) Infections
(7) Others as determined by the Department Chair

18.3.3.4 Methods for evaluation may include:

(1) Chart review
(2) Direct observation
(3) Statistical review
(4) Proctoring
(5) Variance reporting

18.3.3.5 Observation time period will be for the first three (3) months for new Practitioners. If fewer than five (5) procedures or less than six (6) admissions have occurred during the first three (3) months, the observation time period will be extended as determined by the Department Chair, not to exceed two (2) months from the date of appointment.

18.3.3.6 For newly granted and/or additional Privileges, the observation period will be determined by the criteria recommended by the Department Chair.

18.3.3.7 At the conclusion of the FPPE, the evaluation will be conveyed to the Practitioner by the Department Chair. The chair of the Credentials Review Committee will be notified of the outcome of each FPPE.

If there is insufficient activity to fulfill the requirements of FPPE, the Practitioner will be required to provide documentation of current clinical competence from other institutions or from peer recommendations.

18.4 Issues Affecting Provision of Safe, High Quality Patient Care

FPPE will be initiated if a quality review committee, the Department Chair or vice chair, or Medical Executive Committee identifies issues affecting the provision of safe, high quality patient care. In such event, the plan for FPPE will be conducted by the quality review committee along with any follow-up actions deemed necessary. The need for a FPPE will be conveyed to the Practitioner by the Department Chair.

18.4.1 FPPE may be initiated upon the following circumstances:

18.4.1.1 For a single major event.

18.4.1.2 For trends or patterns that significantly and undesirably vary from established patterns of clinical practice, recognized standards, or from that of peers.

18.4.1.3 A significant staff or patient complaint.

18.4.1.4 When the results of an organizational improvement activity or monitoring function identify a significant deviation from accepted standards of practice.

18.4.1.5 A breach of behavioral standards.

18.4.1.6 Repeated failure to follow Hospital/Medical Staff Policies, Medical Staff Rules and Regulations, or Medical Staff Bylaws.

Sources for identifying cases for review include, but are not limited to: chart reviews, quality indicators, data from Medical Staff committees, patient or family complaints and variance report forms. The Hospital's peer review procedure is set forth in applicable Hospital Policy, as such Policy may be amended from time to time.

18.5 Ongoing Professional Practice Evaluation (OPPE):

The Medical Staff will conduct periodic performance reviews of all current Practitioners utilizing performance indicators and specialty-specific indicators. Specific special medical

Privilege criteria will be utilized as applicable. Information resulting from the OPPE is used to determine whether to continue, limit, or revoke existing Privileges or initiate a problem specific focused review. Data will be reviewed at least every eight (8) months and retrospectively from reappointment/Privilege to reappointment/Privilege periods and will be reported to the Department Chair. The Department Chair will share the data with the Practitioner and intervene as appropriate. Data may be obtained from outside facilities where the Practitioner has activity where there is not active participation of Privileges during the review period.

Information used for an OPPE may be acquired from one of the following:

1. Chart review.
2. Direct observation.
3. Monitoring of diagnostic and treatment techniques.
4. Discussion with other individuals involved in the care of the patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

Relevant information obtained from an OPPE is integrated into performance improvement activities while preserving its confidentiality. If there is uncertainty regarding the Practitioner's performance, the Medical Staff will follow the course of action defined in the Medical Staff Bylaws, Rules and Regulations and Hospital/Medical Staff policies for further evaluation of the Practitioner.

ARTICLE XIX: RESPONSE TO INQUIRIES FROM A DEPARTMENT QUALITY COMMITTEE

REFERRAL OF CASES: The patient care issues on the agenda of the QA Committee come from a variety of sources, including risk management, legal, infection control, incident reports, rapid response teams, other departmental QA committees, root cause analyses, patient advocacy, mortality review, case management, and various communications from other parties including residents, attendings, quality staff or miscellaneous staff. Residents, nursing and other staff may be asked to complete and present case reviews.

DISPOSITION OF CASES: All cases reviewed by the QA Committee are assigned a severity level using a standard tool. Any staff directly involved in the issue being discussed will be asked to leave the room for severity scoring. The possible action/final disposition for each severity level is noted. The QA Committee can refer cases for peer review utilizing the final disposition section of the severity scoring tool. If the practitioner is a house officer, peer review disposition is referred to the program director per the house staff manual. If the practitioner is an attending physician, peer review disposition is referred to the Peer Review Committee per the Medical Staff Bylaws. All cases must be entered into a Clinical Quality Database (MIDAS) for tracking and trending purposes.

ARTICLE XX: ADOPTION AND AMENDMENT OF MEDICAL STAFF RULES AND REGULATIONS

Initial adoption of the Rules and Regulations shall require approval by the Board of Directors, followed by a majority vote of the Medical Executive Committee.

Thereafter, any amendment of Rules and Regulations shall require approval by a majority vote the Medical Executive Committee at a regular or special meeting.

Any amendment or adoption will become effective after approval by the Board of Directors. A copy of these Rules and Regulations shall be sent to each Practitioner/AHP with, as applicable, appointment and/or Privileges at the Hospital.

ARTICLE XXI: RULES OF CONSTRUCTIONS

These Rules and Regulations are not to be read to be in conflict with any provision of the Medical Staff Bylaws or UH System Policy. If a rule or regulation seemingly conflicts with a Bylaw provision or specific UH System Policy, they shall be construed, if possible, so that effect is given to both. Further, if a conflict between a Bylaw provision and a Rule and Regulation is irreconcilable, the Bylaw provision shall prevail.

ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee this ___day of _____

_____
Chair, Medical Executive Committee

Approved by the Board of Directors this ___day of _____.

_____
Chair, Board of Directors