MEDICAL AND ALLIED HEALTH STAFFS OF MEMORIAL REGIONAL HOSPITAL AND THE JOE DIMAGGIO CHILDREN'S HOSPITAL RULES AND REGULATIONS

The Medical Staff Rules and Regulations define the Medical Staff's and Allied Health Staff's obligations to Memorial Regional Hospital and the Joe DiMaggio Children's Hospital and the way care is delivered to patients at these facilities. These Rules are applicable to all Medical Staff and Allied Health Staff members and set the parameters for Departmental Rules and Regulations. Members of the Medical Staffs and Allied Health Staffs should review specific Rules and Regulations pertaining to the Department in which they hold privileges for any additional requirements. Medical Staff and Allied Health Staff members are also required to comply with Hospital Policies.

A. ADMISSIONS AND DISCHARGES

1. Members of the Medical Staff must comply with all Hospital Policies and Procedures relating to admission and discharge of patients.

2. Patients may be admitted to Memorial Regional Hospital only by members of the Medical Staff who have admitting privileges to this facility. Patients may be admitted to the Joe DiMaggio Children's Hospital only by members of the Medical Staff who have admitting privileges to this facility. Physician extenders may not admit patients.

3. Except in emergencies, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

4. A provisional diagnosis must be on the chart at the time of admission on all patients admitted under all categories. On all admissions, the history and physical examination must be completed within 24 hours of the admission of an inpatient. A statement with regard to the course of action planned for the patient must be included. In the event that the admission is an emergency or urgent admission, the patient should be seen by a physician and a note placed in the record immediately. In the event of an elective admission, the patient should be seen within 24 hours of admission and a note recorded. Patients may be admitted to the intensive care units by a physician in consultation with the emergency room physician provided that there are admitting orders and provided that the patient is seen by a physician within a timely fashion as the clinical situation dictates, but no longer than four hours from the time of the admission order. Patients admitted or transferred to telemetry need to be seen in a timely fashion, as the clinical situation dictates, but no longer than 12 hours from the time of the admission or transfer order.

5. Any question as to the appropriateness of an admission, transfer, or discharge from a Critical Care Unit should be decided by consultation between the attending practitioner and his Department Chief or a designated member of the Critical Care Committee.

6. Members of the Medical Staff shall commence discharge planning at the time of admission so that diets, prescriptions, and other necessary services such as social services may be accomplished without delay. Patients will be discharged as soon as they are stable and no longer require hospitalization.

7. Patients may only be discharged by order from a member of the Medical Staff. Within 24 hours of discharge, the attending medical staff member shall ensure that the record's face sheet is complete, the principal and other diagnoses and/or procedures performed are stated, and the patient has been given discharge instructions and the record signed. Patients who sign out against medical advice may not necessarily have a discharge order written by the attending medical staff member. In all cases, the face sheet (attestation) must be signed within 24 hours of discharge. Physician extenders may not discharge patients.

8. Following the routine uncomplicated delivery by an obstetrical patient who is deemed stable and ready for discharge on post-partum day one, but who must stay until the following day due to neonatal considerations (PKU testing at 48 hours, etc.), a "discharge in the morning" order is acceptable. However, if within the following 24 hours there is a significant change in the patient's clinical status, the patient must be seen prior to discharge.

B. CONSENTS

1. The member of the Medical Staff or member of the Allied Health Staff who has privileges to order or perform the treatment or service is responsible for obtaining informed consent in accord with prevailing professional standards of care and applicable law. Informed consent shall be documented through an appropriate progress note or through a consent form.

2. Members of the Medical Staff are responsible for providing information to patients or their legal representatives in accord with the prevailing professional standards of care, about the patient's condition, medications, treatments, and care to minimize the risks of injury.

C. TRANSFERS AND DEATH

1. No patient will be transferred within the institution from one section to another without such transfer being approved by the attending physician.

2. When a patient is to be transferred to another institution, the hospital's Standard Practice regarding transfers and all applicable laws must be adhered to.-

3. Any Medical Staff member initiating a transfer to Memorial Regional Hospital or the Joe DiMaggio Children's Hospital will be the attending physician at Memorial Regional Hospital or the Joe DiMaggio Children's Hospital, if applicable, or if not applicable, he will be responsible for the patient at Memorial Regional Hospital or the

Joe DiMaggio Children's Hospital to the extent of his privileges. Additionally, the Hospital's Standard Practice regarding transfers and all applicable laws must be adhered to.

4. Whenever a patient is transferred from one member of the Medical Staff to another member of the Medical Staff, there must be two notes written in the medical record: one documenting the transfer from the transferring physician, the second documenting acceptance by the receiving physician.

5. In the case of a death, the Office of the Medical Examiner shall be notified whenever appropriate or required - see Hospital's Standard Practice.

   Recognizing that performing an autopsy on every death may not be possible and because of limited resources, and to prevent dissemination of infectious material at autopsy from high-risk infections and contagious diseases to personnel and the environment, it is urged that postmortem examinations on hospital patients be clinically oriented and performed for only clearly defined objectives.

   After appropriate notification and with appropriate consent, in deaths not accepted or requested by the Medical Examiner, members of the Medical Staff should attempt to secure autopsies for all deaths in which the cause of death or a significant major diagnosis cannot be determined within reasonable certainty on clinical grounds.

   When an autopsy is performed, the pathologist will communicate his findings with the attending practitioner and any consultants on the case.

D. ASSIGNED PATIENTS

1. All patients presenting themselves for admission and not having an attending practitioner who is a member of the Medical Staff will be known as "assigned" patients and will be assigned to a designated member of the Medical Staff concerned with the treatment of the condition which necessitated the admission. In instances when an attending physician or specialist cannot be reached or obtained for an admitted patient, the physician on call for the emergency room for that particular specialty will be contacted to handle the emergent matter. The specialist on call to the emergency room will be available for consultation on admitted assigned patients. The emergency room on-call rotation is considered the safety net for these types of situations.

2. Departments will establish a rotating list of members of the Medical Staff responsible for the care of assigned patients. It is this practitioner's responsibility to care for an assigned patient for up to 30 days following hospital discharge (unless a Department specifically stipulates otherwise). Patients signing out of the hospital "against medical advice", either before or after admission, are no longer the responsibility of the practitioner to whom they were assigned. If they return to the hospital at a future date, they will be assigned to the practitioner on call.

3. Assigned patients who are treated by Emergency Department physicians and who require follow-up care on an outpatient basis by a member of the Medical Staff will be referred to members of the Medical Staff on duty according to the schedule established for care of assigned patients. Follow-up care must be provided within three business days.

4. Consultations for assigned patients will be requested of the specialist on call when such specialty call rotation is available.

E. PHYSICIAN COVERAGE

1. All members of the Medical Staff will assure that in their absence there is coverage for their patients by a member of the Medical Staff who has the same or substantially the same privileges.

2. In the event of an uncovered absence, the Administrator or his designee will have the authority to notify the Chief of the member's Department or his designee. The Chief will accept responsibility for the care of the patient or name another member of the Medical Staff to be responsible for the unattended patient.

F. ORDERS/CONSULTATIONS

General Orders

1. All orders for treatment shall be written by a member of the Medical Staff or by members of the Allied Health Staff who have clinical privileges to write orders. Telephone and/or verbal orders may be given by members of the Medical Staff or by members of the Allied Health Staff who have clinical privileges to write orders. Telephone and/or verbal orders may be given to a properly authorized person (a registered nurse, pharmacist in relation to drug orders or drug-related orders, a respiratory therapist in relation to pulmonary treatments, registered physical therapist or registered occupational therapist, certified speech and language pathologist, all imaging technologists (MRI technologist, Diagnostic Radiology technologist, Ultrasound technologist, Nuclear Medicine technologist and CT technologist), and registered dietitian in relation to their respective fields of specialty). Telephone and/or verbal orders shall be signed by the person to whom dictated.

Within 30 days after discharge, the responsible practitioner or his associate shall sign such telephone and/or verbal orders with the following exceptions:

a. Emergency psychiatric treatment orders must be signed within 24 hours;
b. Seclusion and restraint orders throughout the facility must be signed within 24 hours;
c. All Hospice orders must be signed within 14 days, other than seclusion and restraint, which must be signed within 24 hours;
d. Orders for Home Health services must be signed within 21 days;
e. Emergency prescriptions of controlled substances listed in Schedule II must be reduced to writing within 72 hours after authorizing an emergency oral prescription; and
f. All orders for oncologic chemotherapy or antineoplastic medications shall be in writing and may not be given as a verbal order or pre-printed order.

2. All corrections, clarifications, late entries or amendments to the medical record must be signed and appropriately timed and dated. The time and date the correction was changed or clarification was made and added to the record should be clearly stated. This includes, without limitation, information about an order that has been completed.

Pharmacy Orders

1. Memorial Regional Hospital/Joe DiMaggio Children's Hospital operates a Closed Hospital Formulary. Members of the Medical Staffs requesting non-formulary drugs must follow the process as described by the Pharmacy and Therapeutics Committee in the Pharmacy Policy and Procedure entitled Hospital Formulary System.

2. Drugs are included in the Formulary by their nonproprietary names, even though proprietary names will continue to be in common use in the hospital. Generically equivalent drugs will be dispensed for the brand name prescribed unless specifically indicated on the medication order. The Pharmacy and Therapeutics Committee may authorize the automatic therapeutic substitution of medications.

3. Certain medications must be renewed as described by the Pharmacy and Therapeutics Committee under the Pharmacy Policy and Procedure entitled "Automatic Stop Orders for Medications":

   a) Albumin - 24 hours

4. The policies and procedures regarding approved abbreviations, available drugs, IV drugs administered by nurses, etc. are to be found in the current Hospital Formulary, Pharmacy Policy and Procedure Manual and/or the Nursing Policy and Procedure Manual.

5. Medication orders must clearly state the dosage and frequency. The use of "prn" with medication orders must be qualified by stating administration times/intervals and the use of "on call" must be qualified by stating for which procedural area.

6. Investigational drugs may be used only under the direct supervision of the principal investigator, with approval from the Institutional Review Board. Principal investigators will be required to flag the outside of the medical record of patients admitted to the hospital who are participating in an investigational study.

Consultations

1. Consultations shall be made by a physician communicating directly with the requested consultant. Physician extenders may not perform consultations.

2. Specific policies regarding consultation on patients in the Critical Care Units and mandatory consultations required by Department rules will be found in the rules and regulations of the specific department and in the critical care policy manuals.

3. Under appropriate circumstances, the Chief of a Department may direct that a consultation be held.

4. The attending physician may request a consultation from representatives of the Behavioral Health Program on a patient who has an admitting diagnosis or working diagnosis relating to alcoholism. Patients who are emotionally ill or who become emotionally ill while in the hospital, or who suffer from drug addiction may be referred for psychiatric consultation and appropriate treatment.

5. The consultant shall record, sign, date, and time a record of his findings and recommendations in every case. The consultant shall sign his full name in a clear and legible manner.

6. Requests for consultation must be responded to within 24 hours of the request.

G. SECLUSION AND RESTRAINT FOR MEDICAL AND BEHAVIORAL PURPOSES IN ACUTE CARE AND BEHAVIORAL HEALTH SETTINGS: Please refer to the Hospital's Standard Practice.

H. CONTINUING MEDICAL EDUCATION

1. Members of the Medical Staff and Allied Health Staff participate in continuing medical education**.** All members of the Medical Staff and Allied Health Staff must comply with licensure requirements for continuing medical education**.** Continuing medical education credits shall be reported as part of the reappointment process and shall relate, at least in part, to the individual's clinical privileges.

2. Continuing Medical Education programs will be offered by the hospital and will

relate to the type and nature of care offered by the hospital, and findings of performance improvement activities**.** The organized Medical Staff helps prioritize hospital-sponsored continuing medical education.

3. Participation in continuing education is considered in decisions about reappointment and revision of clinical privileges.

I. <u>DUES</u>

1. The Executive Committees shall establish the annual Medical Staff dues. Medical Staff dues will be used to further the purposes of the Medical Staff, which may include donations to the Foundations of the Memorial Healthcare System.

2. Dues are payable at the start of each fiscal year, May 1; the Director of Medical Staff Services will send notices to each member on or about that date. Final reminder notices will be sent during the month of August. Physicians appointed on or after January 1 of the same year will be exempt from paying dues for that year.

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3. Any member of the Staff who has not paid his dues in full by October 1 will automatically be suspended from the Medical Staff. Immediately upon full payment of his dues, the suspension is automatically rescinded and previous privileges reinstated. This automatic reinstatement applies only for suspensions that are for less than 30 days.

4. The Executive Committee shall have the power to make special assessments over and above the regular dues, not to exceed $100 per year, for matters of emergency nature. Any action to assess the medical staff more than $100 per year can be made only by a majority vote of the entire medical staff. Such special assessments must be paid within 30 days of the mailing of the notice.

5. Members of the Affiliate Medical Staff of Joe DiMaggio Children's Hospital will pay annual medical staff dues in the amount of $50.

J. <u>MEDICAL RECORDS</u>

The attending physician shall be responsible for a medical record containing sufficient information to identify the patient, support the diagnoses, justify the treatment, document the course and results, and promote the continuity of care among healthcare providers for the patient.

<u>History and Physical- Inpatients</u>

An admission history and physical shall be completed within 24 hours of admission. A complete history shall include the chief complaint, details of the present illness, medical review of body systems, and when appropriate, an assessment of the patient's emotional, behavioral, social status and psychological needs; and relevant past, social and family histories.

The history of children and adolescents shall include an evaluation of the patient's developmental age, consideration of educational needs and daily activities, as appropriate; reference to the patient's immunization status and the family's and/or guardian's expectation for, and involvement in the assessment, treatment and continuous care of the patient.

Obstetrical records will additionally include all prenatal information. A durable, legible, original, or reproduction of the office or clinical prenatal record is acceptable. An interval admission note is required to record any subsequent changes in condition or physical exam.

Psychiatric records will include a psychiatric evaluation form or report. The evaluation will contain the chief complaint, history of present illness, past psychiatric history, mental status exam, past medical history and physical status, diagnosis, problem list, goals for hospitalization, treatment plan, estimated length of stay, criteria for termination of inpatient treatment, post-discharge plans, and prognosis. Physician involvement in the multidisciplinary treatment plan shall be documented for patients admitted for psychiatric or substance-abuse services.

A complete history and physical performed within 30 days prior to the hospital admission may be utilized if:

- A durable legible copy of the report is placed in the patient's hospital record; and
- An appropriate assessment is recorded within 7 days prior to admission or 24 hours after admission confirming that the procedure or care is still necessary and the history and physical is still current. An appropriate assessment includes a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed; and
- The physician or other individual qualified to perform the history and physical writes an update note addressing the patient's current status and/or changes in the patient's status <u>regardless of whether there were any changes in the patient's status</u>, within 7 days prior to or within 24 hours after admission; and
- The update note is recorded on or attached to the history and physical or in the progress notes.

The physical examination will reflect a comprehensive current physical assessment. A statement of the conclusions or impressions drawn from the admission history and physical and a statement of the course of action planned for the patient is documented.

The history and physical examination is completed prior to the performance of surgery. Surgery will only be performed after a history, physical exam and preoperative diagnosis are recorded in the medical record, except when the attending physician documents that a delay in surgery will be detrimental to the patient.

The history and physical performed by the emergency room physician does not fulfill the requirements of this section.

The attending physician shall countersign (authenticate) the history and physical examination within 24 hours when it is recorded by a member of the house staff, or appropriately credentialed allied health practitioners. The attending physician must document a note that includes pertinent clinical findings, diagnosis and/or differential diagnosis, planned course of action.

History and Physical – Observation and Ambulatory Patients

A pertinent, abbreviated history and physical may be recorded for non-inpatient services to include: ambulatory surgical, endoscopy, special procedures (including cardiac catheterizations), patients undergoing conscious sedation and observation cases.

History and Physical – Observation Patients

A pertinent abbreviated history and physical examination shall be recorded for observation patients. An abbreviated history and physical shall include the chief complaint, details of present illness, significant past medical history, medications, allergies, relevant physical examination to include a minimum of heart and lung exam, the diagnosis or impression, and the plan of treatment.

An abbreviated history and physical performed within 30 days prior to the hospital admission may be utilized if:

- A durable, legible copy of the report in placed in the patient's hospital record;
- An appropriate assessment is recorded within 7 days prior to admission or 24 hours after admission confirming that the procedure or care is still necessary and the history and physical is still current. An appropriate assessment includes a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed; and
- The physician or other individual qualified to perform the history and physical writes an update note addressing the patient's current status and/or changes in the patient's status, regardless of whether there were any changes in the patient's status, within 7 days prior to or within 24 hours after admission; and
- The update note is recorded on or attached to the history and physical or in the progress notes.

History and Physical – Ambulatory Patients

A pertinent, abbreviated history and physical examination shall be recorded prior to an ambulatory procedure. An abbreviated history and physical shall include the chief complaint, details of present illness, significant past medical history, medications, allergies, relevant physical examination to include a minimum of heart and lung exam, the diagnosis or impression, and the plan of treatment.

An abbreviated history and physical performed within 30 days prior to the ambulatory encounter date may be utilized if:

- A durable, legible copy of the report is placed in the patient's hospital record; and
- An appropriate assessment is recorded within 7 days prior to the ambulatory encounter date, confirming that the procedure or care is still necessary and the history and physical is still current. An appropriate assessment includes a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed; and
- The physician or other individual qualified to perform the history and physical writes an update note addressing the patient's current status and/or changes in the patient's status regardless of whether there were any changes in the patient's status, within 7 days prior to the ambulatory encounter date; and
- The update note is recorded on or attached to the history and physical or in the progress notes.

Orders

All orders shall be signed, dated, and authenticated within 30 days following discharge. Please refer to the Section in these rules and regulations regarding authentication of telephone and/or verbal orders. Physicians will be required to record their six-digit ID number on all orders along with their signature. It is also recommended that physicians print their name.

Progress Notes

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability of the patient. All patients shall be reassessed **by the responsible physician** daily and a progress note written. Patients in the Transitional Care Unit must be seen at least once every 72 hours or more often if warranted by the patient's condition.

Consultations

Consultants shall show evidence of a review of the medical record and the patient through the recording of pertinent findings on examination, opinions and recommendations in the medical record.

Operative Reports

Inpatient and outpatient operative reports shall be dictated immediately after surgery and contain a description of the findings, any specimens removed, the technical procedures used, the post-operative diagnosis, estimated blood loss, and the name of the primary surgeon and any assistants. The transcribed report shall be signed by the surgeon and will be filed to the medical record as soon as possible after surgery. In addition to the dictated report, a comprehensive handwritten operative progress note shall be entered to the medical record immediately after surgery and contain a description of the findings, any specimens removed, the technical procedures used, the post-operative diagnosis,

estimated blood loss, and the name of the primary surgeon and any assistants.

Delivery Notes

A delivery note will be recorded for all vaginal deliveries. All C-sections require a dictated or written operative report that includes a description of the findings, any specimens removed, the technical procedures used, estimated blood loss, the post-operative diagnosis, and the name of the primary surgeon and any assistants.

Discharge Summary

A discharge summary shall be written or dictated at the time of discharge or no later than 30 days post-discharge for all patients hospitalized over 48 hours, except for normal newborns and normal, uncomplicated obstetrical cases. Summaries shall be written or dictated on all expirations and complicated obstetrical cases regardless of the length of stay. A final progress note may be substituted for the discharge summary for normal newborns, uncomplicated obstetrical cases and those cases of a minor nature hospitalized for 48 hours or less.

The discharge summary will concisely state the indication for hospitalization, hospital course, significant findings, procedures performed and treatment rendered, the condition of the patient on discharge and any specific instructions at discharge relating to diet, activity, medications and follow-up care. The condition of the patient at discharge is stated in terms that permit measurable comparison with the condition on admission. The attending practitioner shall authenticate all summaries.

A transfer summary may be substituted for the discharge summary in the case of the transfer of a patient to a different level of hospitalization.

Symbols and Abbreviations

Symbols and abbreviations may be used only when the Medical Staff has approved them. An official record of the approved abbreviations resides on the Healthcare System's Intranet as a Standard Practice.

All Clinical Entries

All clinical entries to the medical record shall be legible and recorded in black permanent ink. Entries shall be accurately dated and authenticated by the responsible practitioner and shall contain the professional title or credential. Authentication is defined as establishing authorship by written signature, identifiable initials or electronic computer key signature.

The individual practitioner whose signature the electronic computer key represents shall be the only one who possesses it and the only one who uses it; it shall not be shared with any other practitioner or staff.

Confidentiality of Medical Records and Information

Original records may not be removed from the hospital's care and custody except by court order, subpoena, or statute. Copies of medical records will be made available to members of the medical staff who have cared for such patients when applicable law permits release and when there is a demonstrated need for the copy of the medical record. In the case of a readmission of a patient, all previous records shall be made available for use of the attending practitioner and consultants. Unauthorized removal of medical records from the hospital is grounds for disciplinary action by the Medical Staff.

Medical Staff members must comply with applicable law and hospital policies regarding access, use, and disclosure of medical information.

K. TELEMEDICINE

The Medical Executive Committee will review the use of electronic communication or other communication technologies that provide or support clinical care at a distance.

The Medical Staff has determined that teleradiology is an acceptable use of electronic communication. Practitioners utilizing teleradiology will be members of the Active Medical Staff with privileges in diagnostic radiology.

L. DISRUPTIVE PRACTITIONER POLICY:

1. Policy: It is the policy of the Memorial Healthcare System that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, Memorial Regional Hospital/Joe DiMaggio Children's Hospital requires that all members of the Medical Staff and other Allied Health Staffs who are granted clinical privileges conduct themselves in a professional and cooperative manner while in any of the facilities of the Memorial Healthcare System.

2. Purpose: The purpose of this policy is to facilitate appropriate patient care and effective operation of the organization by promoting a safe, cooperative, and professional environment, and to the extent possible, prevent or eliminate conduct that disrupts the operation of the organization, adversely affects the ability of others to do their jobs, creates a hostile work environment for employees or other medical staff members, interferes with an individual's ability to practice competently, or diminishes the image and reputation of the Memorial Healthcare System and its facilities.

3. Definition: Unacceptable disruptive conduct includes, but is not limited to, the following:
a. Attacks (verbal or physical) leveled at other appointees to the medical staff, hospital personnel, or patients, which are personal, irrelevant, or go beyond the bounds of reasonable professional conduct;
b. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care, or attacking particular physicians, nurses, or Healthcare System policies;

c. Non-constructive criticism addressed to another individual in such a way as to intimidate, undermine confidence, belittle, or imply stupidity, or incompetence.
d. Sexual harassment as defined by the Board policy; and
e. Use of racial, ethnic, sexual, or religious terms in a manner intended to insult, intimidate, disparage, or belittle.

4. Documentation:
a. Date and time of the questionable behavior;
b. If the behavior affected or involved a patient in any way, the name of the patient;
c. Circumstances that precipitated the situation;
d. Description of the questionable behavior limited to factual, objective, language;
e. Consequences, if any, of the disruptive behavior as it relates to patient care; and
f. Record of action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

5. Guidelines: If a member of the Medical Staff or Allied Health Staff fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with the following policy: (a) A single documented incident will be investigated by the Director of Medical Affairs or his/her designee and a confidential one-on-one discussion may be held with the physician; or (b) A single egregious incident or a series of repeated incidents may be handled in the following manner: a formal meeting with the physician in question, the Chief of the Department, the Chief of Staff, the Director of Medical Affairs, and the facility Administrator will be held; the Chief of Staff, Chief of a Department, and the Director of Medical Affairs may elect to refer the practitioner to the Physician's Recovery Network. Memorial Healthcare System may use the PRN for purposes of evaluation and/or treatment. Depending on the seriousness of the situation, corrective action or summary suspension may be warranted. The steps outlined in Articles 8 and 9 of the Medical Staff Bylaws for Corrective Action or Summary Suspension will be followed.

M. PRACTITIONER HEALTH POLICY:

It is the policy of the Memorial Healthcare System to be sensitive to a practitioner's health or condition and to assist the practitioner in retaining or regaining optimal professional function, in order to provide quality patient care.

The goal of the Medical Staff is to assist with rehabilitation, rather than discipline, and to aid practitioners in retaining and regaining optimal professional functioning consistent with protection of patients.

The process will include:

- The Medical Staff Leadership will provide education to the medical staff and hospital staff about illness and impairment recognition issues specific to physicians and other allied health practitioners. This may be accomplished through continuing medical education programs, distribution of information to the staff, or presentations at departmental/section meetings.

- The Medical Staff Leadership will assist those willing to undergo treatment and rehabilitation. The Director of Medical Affairs may receive a referral from the practitioner whose health is at issue (self-referral), the Credentials Committee, Administration, the Board of Commissioners, or any concerned individual. The Medical Staff will assure the confidentiality of those individuals referring practitioners with potential health problems.

- The Medical Staff leadership will assist with facilitating the confidential diagnosis, treatment and rehabilitation of practitioners suffering from a potentially impairing condition. They will assist with the referral of the affected practitioner to the appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern. When there is reason to suspect a practitioner may be impaired, the Director of Medical Affairs will contact the Director of the Impaired Practitioner Program of the State of Florida who will assist in arranging for evaluation and/or treatment. The practitioner may be allowed to take a voluntary leave of absence.

  The Physician Recovery Network in accordance with the practitioner's contractual agreement will monitor the practitioner. The hospital may impose any additional monitoring requirements it deems appropriate until the rehabilitation or any disciplinary process is complete and may periodically review thereafter.

- If at any time during diagnosis, treatment or rehabilitation, it is determined that a physician is unable to safely perform the privileges he or she has been granted, the matter will be forwarded to the Medical Staff leadership and administration for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements. Disciplinary action as outlined in the Medical Staff Bylaws will be followed.

- The Medical Staff Leadership will maintain the confidentiality of the physician seeking or referred for assistance except as limited by law, ethical obligation, or when the safety of patient's is threatened.

- Documentation is required for evaluation of the credibility of a complaint, allegation or concern. Evidence substantiating the behavior of the impaired practitioner will include, but is not limited to, the following:

  1. Date and time of the behavior;

2. If the behavior affected or involved a patient in any way, the name of the patient;
3. Circumstances surrounding the situation;
4. Description of the behavior limited to factual and objective information;
5. Consequences of the behavior, if any, as it relates to patient care; and
6. Record of action taken to remedy the situation including date, time, place, action, and name(s) of those intervening;

N. PEER REVIEW POLICY:

The Medical Staff has, through the Department Chief (or his designee), the ongoing responsibility to perform peer review. Peer review will be conducted in the following circumstances: (a) for any case that is identified from standard performance improvement indicators; (b) for complaints from patients, family, staff, or other physicians; (c) risk management issues; and (d) any issue identified that impacts patient care or customer service.

The mechanism for peer review is as follows:

1. The clinical resource manager initiates the peer review through case review and summarizes the pertinent issues.
2. A review is conducted by a peer or peers. The definition of peer is physician to physician, dentist to dentist, podiatrist to podiatrist, etc. For purposes of performance improvement, a peer is further defined as a health care practitioner on the Medical or Allied Health Staffs or an outside expert whose training, experience, and current practice is in the same field as the practitioner being reviewed or whose training, experience and current practice is relevant to the procedure(s) being reviewed.
3. The chief may elect to appoint a committee or panel to review the case.
4. The Conflict of Interest Policy as identified in the Medical Staff Bylaws must be followed when assigning a peer reviewer.
5. Peer review by an outside agency may be required in cases where there is no peer available or all peers have a conflict of interest.
6. Participation by the individual whose performance is being peer reviewed will include letters of inquiry or the steps outlined in Article 8 of the Medical Staff Bylaws if corrective action is indicated.

The following actions will be taken as a result of the peer review:

1. Peer reviewer finds no issue or no deviation from standard of care and no complication or adverse event. Trend to practitioner file.

2. Peer reviewer identifies an issue with the case that may be a deviation from standard of care. Letter of inquiry is sent to the practitioner.

   a. If response explains event - trend to practitioner's file
   b. If response is not accepted, but the issue is minor - letter of education may be applicable and trend to practitioner's file
   c. If response is not accepted and the issue is serious or if there is a trend of similar problems, a letter of concern or corrective action may be warranted

3. Whenever a letter of inquiry, education, or concern is sent to a practitioner, the letter should be signed by the Chief of Department or his designee

4. In the case of letters of inquiry, the letter should be sent certified mail and the letter should include a statement that a response is expected within 30 days; if a response is not received within 30 days, the Director or Associate Director of Medical Affairs should be notified and the Director or Associate Director may elect to call or write the practitioner; if no response is received within 14 days of this notification the matter will be brought to the Executive Committee for disposition of the case.

5. Documentation of the peer review will be trended as part of the Morrissey Concurrent Care Manager (MCCM) Program and the written back-up review material and related correspondence will be filed in the physician's peer review file in the Medical Staff Services Department at the facility where the peer review was conducted, with a copy sent to the Medical Staff Services Department for the Memorial Healthcare System for consideration at the time of reappointment when credentialing and privileging decisions are considered.

6. If for any reason there is concern or disagreement regarding the findings made by a peer reviewer, the case should be presented to the Director of Medical Affairs for his review.

O. Disaster Privileges - Credentialing Physicians in the Event of a Mass Casualty Incident

a. Any practitioner providing patient care must be granted privileges prior to providing patient care, even in a disaster situation.

b. The following procedure will be followed for granting emergency privileges in a mass casualty incident when the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs.

- The Command Center will determine that volunteer physicians are required;
- Volunteer physicians will be required to report to the Medical Staff Unit leader and provide the following documents:
    1. Valid professional license;
    2. Photo identification (i.e., driver's license, current hospital identification badge, disaster medical assistance team identification);
    3. Certificate of malpractice insurance or letter of financial responsibility; and
    4. List of current hospital affiliations.

- Licensure and current hospital affiliations will be verified as soon as possible.

- Privileges to assist during the Mass Casualty Incident will be granted by the Incident Commander (CEO/designee) upon the recommendation of the Medical Staff Director on a case-by-case basis. These privileges terminate automatically

when the emergency situation no longer exists, or as determined by the Incident Commander.

- Volunteer physicians will be paired with a member of the Active Medical Staff and will act only under the direct supervision of an Active Medical Staff member.

- The credentialing verification process begins as soon as the immediate situation is under control. The same process used for granting temporary privileges will be followed.

P. Graduate Medical Education

Residents will not hold membership on the medical staff and shall not be granted clinical privileges. Rather, they shall be permitted to function clinically in accordance with written training protocols approved by the Chairman of the Professional Graduate Education Committee in conjunction with the residency-training program. The protocols will delineate the roles, responsibilities and patient care activities of the residents and which level of resident may write patient care orders, and under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol will also describe the mechanisms through which resident directors make decisions about a resident's progressive involvement and independence in delivering patient care.

Licensed independent practitioners with appropriate clinical privileges on the Medical Staff will supervise all residents.

The Professional Graduate Education Committee will:
- Be chaired by a member of the Medical Staff involved in graduate medical education;
- Meet at least annually;
- Review the residency programs affiliated with the Memorial Healthcare System;
- Review the safety and quality of patient care provided by the residents;
- Review the supervisory needs of the residency program(s); and
- Provide a written report to the Executive Committee who will in turn report to the Governing Board.

Q. Organized Health Care Arrangement (OHCA)

Memorial Healthcare System recognizes that all members of the Medical Staffs and Allied Health Staffs of all Memorial Healthcare System Hospitals participate in an Organized Health Care Arrangement (OHCA) as defined by 45 CFR 164.501 as respects care rendered in all Memorial Healthcare System Hospitals.

All Medical Staff and Allied Health Staff members have agreed to comply with all requirements of the Rules and Regulations of the Medical Staff and Allied Health Staffs. Compliance with the Memorial Healthcare System Privacy Program as regards Memorial Healthcare System Hospital records is expressly required under these Rules and Regulations.

These Rules and Regulations were approved by the Medical Staff of the Joe DiMaggio Children's Hospital on October 4, 2004 and by the Medical Staff of Memorial Regional Hospital on October 11, 2004. The Board of Commissioners adopted these Rules on October 27, 2004.

APPROVAL:

______________________________	________________________
CHIEF OF STAFF MEMORIAL REGIONAL HOSPITAL	DATE

______________________________	________________________
CHIEF OF STAFF JOE DIMAGGIO CHILDREN'S HOSPITAL	DATE

______________________________	________________________
CHAIRMAN, GOVERNING BOARD BOARD OF COMMISSIONERS	DATE