

**Wadley Regional Medical Center at Hope**

A STEWARD FAMILY HOSPITAL



# **MEDICAL STAFF RULES AND REGULATIONS**

Approved by Board of Directors: Effective June 26, 2019

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## **GENERAL**

1. This document sets forth the Rules and Regulations of the Wadley Regional Medical Center (WRMC-Hope) at Hope Medical Staff and is subject to the provisions of the Medical Staff Bylaws. The terms defined in the Medical Staff Bylaws shall have the same meanings herein.
2. These Rules and Regulations will be reviewed at least every two calendar years and when needed due to regulatory changes or at the request of the Medical Staff and may be adopted, amended, revised, modified, restated and repealed in the manner set forth in the Bylaws.

## **ADMISSION AND DISCHARGE**

1. Patients may be admitted and discharged only on order of a member of the Medical Staff with appropriate privileges. The Hospital will not be required to accept cases for which facilities for proper care are not available. Patients can be admitted to observation status while only undergoing tests or therapy. Observation status shall not be used as a substitution for an admission which meets approved admission criteria. Proper safety precautions shall be taken with respect to patients who are known to be suffering from drug abuse, alcoholism and mental illness.
2. Physicians must provide justification for the admission within the medical record within 24 hours.
3. All patients admitted to the Hospital must be seen by the admitting physician within twenty-four (24) hours.
4. In any non-scheduled admission, including direct admissions from a physician's office, skilled nursing facility, or other non-acute setting, the practitioner shall first contact the admitting office or, if closed, the house supervisor to ascertain if there is a bed available and receive a bed assignment for the patient.
5. A patient to be admitted on an emergency basis shall be given the opportunity to select an appointee of the staff to be responsible for the patient while in the Hospital. The on-call physician for the appropriate specialty will assume responsibility where no such selection is made or where the selected practitioner does not assume responsibility for the patient.
6. If a patient leaves the Hospital against the advice of an attending practitioner or without proper discharge, a notation shall be made in the patient's medical record. Patients may not be discharged to an outpatient facility or physician's office for urgent or emergent procedures or diagnostic testing when the hospital has the capacity and capability to provide care.
7. Practitioners shall abide by the Hospital's Utilization Management Plan, including the appropriateness and medical necessity of admission, continued stay, supportive services, and discharge planning. Discharge planning may be initiated by Social Services upon admission of the patient without the need of a physician's order.
8. All elective (non-urgent) admissions and certain outpatient procedures referred to the Hospital are pre-certified by the admitting physician's office with the appropriate third party payor. Authorizations must be obtained and communicated to the Admitting Department the day prior to admission or procedures. The Case Management Department certifies emergency admissions within one business day of the admission. Patients whose payor does not require precertification must still meet medical necessity for admission and may be screened for appropriateness by the Case Management Department prior to admission.
9. There is a provisional diagnosis and a preliminary plan of care documented by the physician at the time a patient is admitted. Exceptions include cases of a life-threatening emergency. In such cases a provisional diagnosis and plan of care is documented within 24 hours of the admission.
10. A hospitalized patient is never to be without an attending physician. The patients will be assessed daily in all cases with the exception of patients admitted on Behavior Health Unit. Any physician who will be unavailable to come to the hospital daily is to name a member of the medical staff who resides in the area to assume the care of the patient in his or her absence. In a situation where a physician has failed to indicate a covering physician, the Chief of Staff has the authority to call any member of the medical staff to serve as attending. Failure to provide coverage for a patient is reportable to the Chief of Staff.
11. Discharge planning is an integral part of hospitalization and begins on admission. The plan, documented

in the medical record, includes the goals to be attained prior to discharge, an assessment of the available resources appropriate to meet the needs of the patient and family after discharge, and when to obtain additional care or treatment. Goals are prioritized and discharge instructions are provided to the patient and those responsible for their care. Case Managers and Social Workers are authorized to initiate discharge planning without a physician order.

12. The patient shall be discharged only on the order of the attending physician or designee.
13. Transfer of Patients to Other Facilities:
  - a) All transfers to other facilities will comply with the hospital protocol for transfer of patients and with all legal and regulatory requirements regarding the transfer of patients from one facility to another;
  - b) The attending physician is responsible for working with the hospital in assuring that the transfer authorized by the accepting facility:
    - i. Identifying and communicating with an accepting physician at the facility;
    - ii. Completion of the patient transfer record outlining the physician's certification for transfer, risk and benefits of transfer and patient's condition; and
    - iii. Documentation in the medical record to include an order for transfer and a final progress note.
14. Transfer of Patients to WRMC at Hope from Outside Facilities:
  - a) Transfers from outside of the hospital are to be coordinated with the hospital admitting or house supervisory staff and require physician acceptance and administrative acceptance;
  - b) The accepting physician assumes the responsibility as attending and is accountable for documenting acceptance of the transfer, future care, communication, and documentation responsibilities of an attending physician;
  - c) Prior to any transfer of a patient from another facility, the hospital supervisor or bed coordinator will acknowledge that there is bed availability.
15. WRMC at Hope will comply with the Arkansas statutes in the determination of death. A person may be pronounced dead by a qualified physician if it is determined that the individual has sustained irreversible cessation of circulatory and respiratory function or Irreversible cessation of all functions of the entire brain, including the brain stem. A determination of death shall be made in accordance with accepted medical standards. (AR Code 20-17-101 – Uniform Determination of Death Act)

When it is determined that brain death has occurred, all medical treatment and life support measures may be discontinued. The prior consent of family or other legally responsible individuals is not required, but consultation with and consent by such persons is recommended. In the event the patient is to serve as a tissue or organ donor, appropriate and necessary life support measures should be continued until the tissue(s) and/or organ(s) have been removed.

The Arkansas Regional Organ Recovery Agency (ARORA) is the designated organ procurement organization in Arkansas. WRMC at Hope complies with all state and federal requirements regarding reporting and facilitating organ recovery and transplantation.
16. Death certificates are the responsibility of the attending physician or designee.

#### **INTENSIVE CARE UNIT**

1. Admissions and discharges to the intensive care unit shall be in accordance with established criteria. Exceptions shall be approved the Chief of Staff.
2. The Intensive Care beds are reserved for those patients requiring a greater than usual intensity of medical care and treatment, and the admission of patients not meeting those criteria shall be actively discouraged.
3. All patients admitted to the Intensive Care Unit shall be seen within four (4) hours after admission or an appropriate time frame based on the patient's condition and circumstances to the unit by the attending physician, or alternatively by a hospitalist.

#### **EMERGENCY SERVICES**

1. At least one emergency medicine physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven days per week. The Emergency Department physician on duty is responsible for the general care of all patients presenting themselves to the Emergency Department.
2. Any patient who comes to the hospital requesting emergency services is entitled to and will receive a Medical Screening Examination (MSE) performed by individuals qualified to perform such examination to determine whether an emergency medical condition exists. The Board of Trustees has the authority to determine who may perform the MSE. An MSE may be performed by an Emergency Department physician, any other physician, or a credentialed ED allied health professional. The examination shall be provided within the capability of the hospital, including ancillary services, available personnel and on-call physicians, to determine whether an emergency medical condition exists.
3. An appropriate medical record and log entry shall be maintained for every person presenting himself to the hospital for emergency treatment, care or evaluation. The log shall be maintained in the order in which patients present themselves for treatment and shall include the disposition of the patient (admission, discharge, transfer, or refusal of evaluation/treatment). The medical record shall include adequate patient identification; information concerning the time of the patient's arrival, transportation, and any treatment received prior to arrival; pertinent history of the illness or injury; history of allergies; significant clinical findings; results of diagnostic studies; diagnosis; treatment rendered; condition on discharge or transfer; and instructions given to patient and/or family relative including prescriptions and follow-up care.
4. There shall be a daily call list for the Emergency Department for each Medical Staff specialty identifying the individual Medical Staff member on call for each 24-hour period.
  - a) Each specialty will be responsible for developing and implementing their own call schedules and will determine the on-call and the methodology for preparation of the schedule. As required by EMTALA, each group practice must clearly identify by name the individual physician that will cover each day assigned to the practice. The call list shall be prepared with the name of an individual physician for each day. Call schedules must be received by the Medical Staff Coordinator no later than the 24th day of each month;
  - b) Each day of the call schedule begins at 7:00 a.m. and ends at 7:00 a.m. the following day;
  - c) Once the schedule is distributed, changes are the responsibility of the physician listed;
  - d) The ED Charge Nurse and the Medical Staff Coordinator shall be notified in writing of any changes made after the schedule is posted and distributed.
5. Each member is expected to serve, without compensation, not more than one day (24 hours) in four on general call, as a matter of medical staff membership except:
  - a) When the Medical Executive Committee and Board determine that Emergency Department Coverage of a particular specialty is not required; or
  - b) When the scope of privileges granted to the staff member reflects a limited scope of practice;
  - c) When the member reaches age sixty-five (65)-and has been an active member of the Medical Staff for five (5) years and requests to be exempted from the ER call schedule and it is determined and approved by Medical Executive Committee, and Board that there is an adequate number of physicians participating in the call rotation to meet the needs of the facility, the request will be granted;
  - d) When contracted arrangements have been made for coverage.
6. Responsibilities of a physician on-call for the Emergency Department shall include the following:
  - a) Being available for all patients in the ED and in other areas of the hospital where an emergent inpatient consultation is needed;
  - b) Seeing patients, or providing for their disposition, when requested by an ED physician, regardless of the patient's financial status;
  - c) Determining that personal communications equipment (e.g., beeper) is in satisfactory working order;
  - d) Informing his/her answering service of the on-call responsibility, including any delegation of on-call responsibility;
  - e) Informing the Emergency Department and the Medical Staff Office, in writing and at least 48 hours in advance, if on-call responsibility is transferred to another physician and ensuring that the covering physician is a member of the Medical Staff, is qualified to take call, and is aware

- of his/her responsibilities;
- f) Responding within 30 minutes by telephone when paged;
  - g) Personally coming to the Emergency Department within sixty (60) minutes when requested to do so by the emergency medicine physician and
  - h) Accepting a referred patient for the initial follow-up visit, if medically appropriate, within the timeframe recommended by the Emergency Department physician, and without regard to method of payment or ability to pay.
- 7. In the event an on-call physician fails to fulfill any of the ER call responsibilities, the Director of Emergency Service is obligated to recommend to the Chief of Staff that appropriate disciplinary action should be taken in accordance with the Medical Staff Bylaws.
  - 8. When a patient presents in the Emergency Department who has a physician on the Medical Staff, the ED staff will provide the appropriate medical screening examination and, if the patient wishes, will notify the patient's private physician of the patient's presence in the ED. If the patient needs to be evaluated further by a specialist or admitted to the Hospital as an inpatient or observation patient, the patient shall be evaluated by the patient's practitioner or the appropriate specialty practitioner on-call. The assigned practitioner shall respond to the Emergency Department physician within 30 minutes by telephone and shall come to the Hospital as promptly as possible if requested by the ED physician. The ED physician shall continue to accept responsibility for the patient until another practitioner assumes responsibility for the patient.
  - 9. The emergency physician shall arrange for an interpretation of imaging studies by a radiologist and comparison of any initial and final interpretation. In cases where the interpretation of the radiologist is different from the initial impression of the emergency physician, the radiologist shall immediately notify the emergency physician and, if known, the patient's primary physician, as soon as possible. The emergency physician maintains the responsibility to assure that significant discrepancies are communicated to the patient or follow-up caregiver.

#### **MEDICAL RECORDS AND ORDERS**

- 1. The attending practitioner will be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current for the patient and shall include identification data; chief complaint; medical history, family history and history of the present illness; physical examination; review of systems; social history; psychosocial needs; impressions; appropriate treatment plan; diagnostic and therapeutic orders; appropriate informed consents; clinical observations, including results of therapy, progress notes, consultations, nursing notes, laboratory and x-ray and other reports; provisional and final diagnosis; medical treatment; tests and results; discharge summary, condition on discharge and instructions given for further care, such as medications, diet or limitations of activity; and autopsy report, if one is performed.
- 2. Pertinent information shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written daily.
- 3. The attending practitioner must sign or must read, edit and countersign all orders, the history and physical examination, when they have been recorded by an advanced practice nurse.
- 4. All clinical entries and summaries in the patient's medical record shall be accurately dated, timed, and authenticated.
- 5. The following persons may make entries in medical records of Hospital patients: members of the Medical Staff, Allied Health Professionals, Registered Nurses, Licensed Practical Nurse, Dietitians, Radiology technicians, Physical therapists, Respiratory therapists, Social workers, Case managers, and Pharmacists within their scope of practice and State Regulations.
- 6. The attending practitioner shall complete the medical record at the time of the patient's discharge, including Outcome of the hospitalization treatment or procedure; Final diagnosis; Disposition of the patient; and Provisions for follow-up care progress notes, and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the medical record will be available in the electronic health record and must in be completed within Thirty

(30) days of Discharge

7. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.
8. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and authenticated by the responsible practitioner at the time of discharge of all patients.
9. A practitioner will be considered delinquent in completion of his medical records if the records are not completed within 30 days of discharge. The physician will be notified of all incomplete and delinquent medical records weekly. If the physician has not completed his or her medical records within the following week (seven days from notification), the physician is placed on suspension. The physician's privileges will be reinstated upon the completion of his or her delinquent medical records, unless there are known extenuating circumstances. In the case of physicians assigned to emergency services, the suspension will be in the form of suspension of privileges to treat or examine patients. The suspension shall continue until the medical records are completed, unless the practitioner provides a justifiable excuse to the Chief of Staff. The Admitting Office shall be notified of this action by the Health Information Management Department. Reinstatement of privileges will be automatic upon the completion of records, and the Director of Health Information Management Department shall inform the Admitting Office. The Health Information Management Department will be responsible for analyzing medical records for the purpose of administering this rule. If a physician is suspended 5 times in a calendar year, the physician will be mailed a certified letter with a request for them to attend the next Executive Committee meeting to explain the delay in completion of the medical records. If the physician fails to show, there may be grounds for disciplinary action.
10. All orders for treatment, medications, and diet must be entered into the patient's Medical Record. An order will be considered to be valid if dictated to authorized personnel and countersigned by the ordering practitioner. Personnel authorized to record verbal orders include the Medical Staff, allied health professionals, Registered Nurses, Licensed Practical Nurse, Dietitians, Radiology technicians, Physical therapists, Respiratory therapists, Social workers, Case managers, and Pharmacists within their scope of practice and State Regulations. The individual receiving the verbal/telephone order shall immediately enter the order into the medical record, authenticate, and date the order, with the time noted, and, where applicable, enter the dose to be administered. The individual receiving the order shall immediately read back the order and the prescribing physician or other authorized practitioner shall verify that the read back order is correct. The individual receiving the order shall document, in the patient's medical record that the order was "read back." Orders for medication must designate drug, dosage and method and frequency of administration. Verbal / telephone orders will not be taken when the physician is on the floor, except in emergency situations or when performing a sterile procedure.
11. Pre-printed orders may be formulated by individual members of the Medical Staff and placed on file at the hospital. These orders must be recorded on the patient's medical record and signed by the physician. Pre-printed orders must be designed in such a way that they may be sufficiently adjusted to meet the individual characteristics and needs of each patient. Designated committee(s) of the Medical Staff may be given the authority to require changes in use of such orders. Pre-printed orders must meet the requirements of the Medical Staff and be reviewed every two years.
12. All diagnostic tests may not be ordered as "daily" unless part of an approved protocol. If the practitioner desires to continue or repeat any tests, there must be an order each day.
13. Outpatient diagnostic tests or treatments must be documented with an order and diagnosis.
14. All orders will be canceled for a patient when transferred to or from the Intensive Care Unit.
15. Clinical Documentation Cerner - (CPOE)
  - a. All medical content such as History & Physical Examinations, Progress Notes, Diagnostic Test Interpretations, Operative or Surgical Reports, and Discharge Summaries in an electronic format within the required timeframe as outlined in these Rules and Regulations.
16. Computerized Physician Order Entry - Cerner (CPOE)
  - a. Orders are required to place orders through Computerized Physician Order Entry (CPOE).
  - b. Exceptions to Computerized Physician Order Entry shall be limited. Orders shall be authenticated within the timeframes outlined within these Rules and Regulation.
  - c. All practitioners must display electronic health record competency consistent with completing

- hospital training before receiving login credentials.
- d. All Practitioners shall be required to complete introductory electronic health record training as well as ongoing competency training of modules pertaining to provider workflow. These include workflows pertaining to clinical documentation capture and computerized order entry.
17. Failure to utilize CPOE or complete the initial required training, or failure to complete any updates concerning, may result in the suspension of clinical privileges

### **INFORMED CONSENT**

Procedures requiring informed consent include the following:

- a. Procedures outlined in the AR medical practice act;
- b. All procedures in which moderate sedation is used, regardless of whether an entry in to a body is involved (i.e., closed reduction);
- c. Moderate sedation;
- d. Complex nonsurgical procedures that involve more than a slight risk of harm to the patient or that may cause a change in the patient's body structure (includes, joint injections);
- e. Transfusion of blood and blood products.

Physician Responsibility of Consents include:

- a) Physician must disclose to the patient those risks or hazards which could influence a reasonable person in making the decision of whether to consent to the treatments;
- b) The patient should be advised not only of the risk and hazards of the treatment, but also of the alternative treatments and the probable results if the patient remains untreated;
- c) Physician's documentation should indicate the physician discussion with the patient including risks involved, as well as the alternative therapies which could be used;
- d) Physician should complete consent form in all cases possible.

### **EMERGENCY PREPAREDNESS PLAN**

There shall be a plan that addresses facility operations in the event of mass casualties at the time of any major disaster or a significant influx of patients during a major disease outbreak, based upon the Hospital's capabilities in connection with other emergency facilities in the community. The plan shall be reviewed and approved by the Staff and the Board.

The incident commander will designate a physician leader to coordinate medical care within the facility. All Medical Staff members must act under the leadership of the designated physician leader. All physicians may be assigned to posts, and it is their responsibility to report to their assigned stations. All policies concerning direct patient care will be a joint responsibility of the Chief of Staff and the President. In their absence, the Past Chief of Staff and alternate in administration are next in line of authority, respectively.

### **MEDICATIONS AND BLOOD**

- 1. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. These shall be used in full accordance with the Statement of Principle involved in the use of investigational drugs in the Hospital and all regulations of the Federal Drug Administration.
- 2. The Medical Staff will comply with the hospital/ Pharmacy policy regarding stop orders. Medications shall be ordered specifically by dosage, frequency, time and duration. These shall be agreed upon by the Pharmacy and Therapeutics Committee in compliance with all State and Federal Regulations.
- 3. Only drugs listed in the WRMC at Hope's Formulary shall be stocked. Any exceptions shall be requested in writing on a Non-Formulary Request and require a written order of the practitioner attending the patient. Such drugs shall be purchased only in the quantities to fill each written order. The practitioner shall be notified at once if the drugs are not available.
- 4. All medications brought into the Hospital by a patient must be sent to the Pharmacy for proper identification if they are to be administered during the hospital stay. The pharmacist will verify the fact that the medications brought in by the patient are, in fact, those that the practitioner has prescribed.
  - a) Medications brought into the Hospital by a patient or his family will not be given to the patient

- during his Hospital stay without the express authorization of the attending practitioner;
  - b) Patients' home medications should be sent home with the patients' family members or given to security to lock up; a receipt for the medications will be placed on the patient's chart.
- 5. Blood which has been cross-matched and is being held for a patient will be held for three calendar days or 72 hours at which time the order for the blood will be canceled.

#### **GENERAL CONDUCT OF CARE**

1. Practitioners are expected to comply with CDC hand hygiene recommendations to reduce the spread of infections
2. Autopsies: Autopsies should be considered in the following circumstances:
  - a) Unanticipated death;
  - b) Death occurring while the patient is being treated under a therapeutic trial regime;
  - c) Intraoperative or intra-procedural death;
  - d) Death occurring within 48 hours after surgery or an invasive procedure;
  - e) Death related to pregnancy or within 7 days of delivery;
  - f) Deaths in admitted infants or children with congenital malformation;
  - g) Infant suspected of Sudden Infant Death Syndrome (SIDS);
  - h) Death of a patient on the Behavioral Health Center;

The Medical Staff shall attempt to secure autopsies in all cases that meet the criteria/indications for autopsies as approved by the Medical Executive Committee, or when requested by the attending physician as follows:

- a) Coroner's cases: accidental deaths, homicides, suicides and deaths within 24 hours of admission to the hospital must be reported to the Coroner. The Coroner may or may not elect to perform an autopsy, but his office has the responsibility and the jurisdiction for the appropriate disposition in such cases. The attending physician is notified when the autopsy occurs.
2. Each member of the Medical Staff with computer terminal access to WRMC at Hope medical records agrees to comply with the information security policies of the Hospital set forth in the Information Security Agreement, System Access authorization and Remote Connectivity Agreement. Such policies include maintaining assigned passwords that allow access to computer systems and equipment in strictest confidence and not disclosing passwords with anyone, at any time, for any reason. Each member of the Medical Staff understands that the records of the patients maintained in the computer system are confidential and that access to such records should be limited to those who have a need to know in order to provide for the continuing care of the patient. Failure to comply with the information security policies of WRMC at Hope by a physician or allied health professional will result in the following:
  - a) Violations will be reported to the PRESIDENT and the Security Officer;
  - b) Documentation of the disciplinary action will be placed in the credentials file of the physician or allied health professional;
  - c) Possible termination of access to the computer system;

#### **PHOTOGRAPHING PATIENTS**

Personal cameras, camera phones or other photographic equipment may not be used for the purpose of taking photographs of patients, visitors, patient care areas, hospital equipment or other proprietary matters. Medical Center cameras are available for photographing patients for documentation in their medical records; copies of photographs will be made available to physicians for their office files upon request.

#### **CONSULTATIONS**

1. Consultation must be obtained when specialized treatment or procedures beyond the level of expertise of the attending physician is required, or when the attending physician does not have clinical privileges to provide the needed treatment.
2. There are two categories of consults: routine and immediate. Members of the medical staff must fulfill routine consult requests within 48 hours of notification of the request for consult. If a consult is deemed to be of an urgent/immediate nature, the consult must be fulfilled within twelve (12) hours of notification

of consult request. For immediate consults, the requesting physician should attempt to contact the consulting physician personally, if possible.

3. Patients placed on ventilators must have an appropriate consult if the attending physician does not have ventilator privileges. Each physician responsible for ventilator management of a patient shall write orders regarding ventilator parameters which may include the use of medical staff approved ventilator protocols.
4. The attending physician must arrange for a consultation when one is requested by the patient or the patient's family.
5. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his or her area of expertise.
6. The attending practitioner is primarily responsible for requesting consultation when indicated from a qualified consultant. A written order will be documented which will permit another practitioner to attend or examine the patient, except in an emergency.

### **PEER REVIEW**

**Ongoing Professional Practice Evaluation (OPPE)** is a process through which the Medical Staff identifies professional practice trends that impact quality of care and patient safety on an ongoing basis and applies to all Medical Staff and Allied Health Providers as privileged through the Medical Staff.

The purpose of this process is to:

- To clearly define the process utilized for facilitating the continuous evaluation of each practitioner's professional practice;
- To define the type of data (criteria/indicators) to be collected for the ongoing professional practice evaluation. (*Note: The criteria defined for Ongoing Professional Practice Evaluation, will be utilized as screening triggers for a Focused Professional Practice Evaluation*);
- To ensure the information resulting from the ongoing professional practice evaluation is used to determine to continue, limit or revoke any existing privileges at the time the information is analyzed;
- To define the process for collecting, investigating, and addressing clinical practice concerns, including the process utilized to identify trends that impact quality of care and patient safety;
- To ensure reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by hospital policy and applicable law;
- To define those circumstances in which an external review or focused review may be necessary;
- To evaluate the strengths and opportunities of an individual practitioner's performance and competence related to his/her privileges.

**Goals of the OPPE process include:**

- Identify opportunities for practice and performance improvement of individual practitioners (Medical and Advanced Practice Staff professionals);
- Monitor for significant trends in performance by analyzing aggregate data and case findings;
- Assure that the process for professional practice evaluation is clearly defined, objective, equitable, defensible, timely, and useful;
- Monitor clinical performance of Medical Staff practitioners;
- Improve the quality of care provided by individual practitioners;
- Provide suggested areas for hospital wide improvement, addressable by focused project teams.

Information collected for OPPE by the Quality Management Department and Medical Staff Office will be reflected within the six areas of core competencies listed below as applicable to areas of practice and will include thresholds:

- **Patient Care:** Admission and procedural activity; appropriate adherence to blood and pharmaceutical use standards;
- **Medical/Clinical Knowledge:** Review of operative and other clinical procedures performed and their outcomes.

- **Practice Based Learning and Improvement:**
  - Compliance with CMS Conditions of Participation;
  - Compliance with DNV Standards;
  - Compliance with applicable core measures;
  - Compliance national Patient Safety goals guidelines and documentation requirements.
- **Interpersonal Communication Skills:** Behavior reports of concern.
- **Professionalism:**
  - Timely and comprehensive medical record completion and response to queries.
- **Systems Based Practice:**
  - Appropriate adherence to Medical Staff approved clinical protocols and policies.

#### **DATA COLLECTION & INDICATORS FOR REVIEW**

Data collection methodologies for inpatient, outpatient, ED, and Ambulatory care on both a concurrent and retrospective basis may include

- periodic chart review;
- direct observation;
- monitoring of diagnostic and treatment techniques;
- discussion with other individuals involved in the care of each patient including other physicians, nursing, and administrative personnel.

All Medical Staff and Allied Health Personnel with clinical privileges will be subject to OPPE review no less than 3 three times within a 24 month reappointment period.

Thresholds for each indicator will be identified as appropriate. When a threshold is exceeded, the Medical Executive Committee will determine if a focused review is required (at which time the Focused Professional Practice Evaluation process will be initiated per the Medical Staff Bylaws. Indicators will be evaluated periodically to determine if the indicator(s) and threshold(s) should be modified.

#### **MEDICAL STAFF OVERSIGHT AND PROCEDURE.**

The Medical Executive Committee will approve data to be collected and will review OPPE data that is collected. The Medical Executive Committee based on the review of the OPPE collected determine if the OPPE performance by the Practitioner is deemed to be acceptable based on thresholds that have been set and approved with no further action to be taken or the Committee will identify any issues that require further review.

Each Medical or Advanced Practice Staff member being evaluated is responsible for cooperating with the OPPE review process when requested.

#### **Focused Professional Practice Evaluation, (FPPE)**

FPPE is a time limited evaluation of Practitioners competence in performing specific privileges. FPPE will occur in all requests for initial appointments, new privileges and when there are concerns regarding the provision of safe, high quality care by a current Medical Staff member or individual with clinical privileges, as recognized through the Ongoing Practitioner Practice Evaluation (OPPE) process. This process includes an assessment for proficiency in the following six areas of core competencies:

- Patient care;
- Medical and clinical knowledge;
- Practice-based learning and improvement;
- Interpersonal and communication skills;
- Professionalism;
- Systems-based practice.

#### **MEDICAL STAFF OVERSIGHT:**

The Medical Executive Committee has primary oversight of the FPPE process. The FPPE process will be integrated with the organization's Ongoing Practitioner Practice Evaluation (OPPE) process. FPPE may be utilized when practitioners with existing privileges have questions arise regarding a practitioner's ability to provide safe, high-quality patient care (OPPE).

## **EVALUATION PERIOD**

- Medical Executive Committee will determine the monitoring duration,
- The duration may be different for different levels of documented training and experience. For example, durations for FPPE may be adjusted based upon:
  - Practitioners coming directly from an outside residency program;
  - Practitioners coming directly from the organization's residency program;
  - Practitioners coming with a documented record of performance of the privilege and its associated outcomes;
  - Practitioners coming with no record of performance of the privilege and its associated outcomes;
  - Duration for initially requested privileges (either new applicant, individuals with existing privileges or for those returning from an extended leave of absence);
  - The FPPE should be completed within 6 months. This will allow for further evaluation, if indicated, prior to the end of the initial appointment cycle;
  - In the event, the practitioner does not have adequate case volume to complete FPPE in 6 months, the FPPE will be extended until volume is sufficient, not to exceed 12 months;
  - All FPPE activities need to be completed prior to the end of the 12 month initial appointment cycle. If the FPPE has not been completed, then unrestricted privileges will not be granted.

## **DATA COLLECTED:**

Information collected for the FPPE by the Quality Management Department and Medical Staff Office may include:

- clinical outcomes data as defined by specific indicators;
- Universal indicators;
- Retrospective chart reviews;
- Direct observation or proctoring;
- Discussion with other individuals involved in the care of each patient including physicians, nursing staff, and administrative personnel;
- Monitoring of diagnostic and treatment techniques;
- OPPE reports from other facilities where the practitioner holds the same clinical privileges (for low-volume practitioners);
- Other information as may be requested by the Medical Executive Committee.

## **MEDICAL EXECUTIVE COMMITTEE RESPONSIBILITY:**

The Medical Executive Committee holds primary oversight of the FPPE process and is responsible for the following:

- Assigning a proctor to perform the following:
  - Directly observe the care and/or procedures being performed, concurrently observe medical management or retrospectively review the completed medical record following discharge and will complete appropriate forms.
  - Ensure confidentiality of proctor results and forms. Submit completed forms to the medical staff office.
  - Submit a summary report at conclusion of proctoring period.
  - If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient, the proctor shall promptly notify the Department Chair.
- Reviewing, approving with or without modifications, and monitoring FPPE Plans, including the duration if not predetermined by departments but in no cases shall it be more than 12 months and normally should be completed within 6 months;
- Making recommendations to the Medical Executive Committee regarding new and ongoing FPPE Plans;
- Recommending to the MEC acceptable completion of the FPPE process or additional evaluation or extension of the initial evaluation timeframe or other actions in accordance with the Medical Staff Bylaws; and
- If at any time during the evaluation period, the Medical Executive Committee becomes aware of concerns about the practitioner's competency to perform specific clinical privileges or care related to

a specific patient(s), it may then take one of the following actions:

- Require Additional or revised evaluation or proctoring requirements to be imposed upon the practitioner;
  - Begin corrective action pursuant to Medical Staff Bylaws;
  - Suspension of privileges.
- Final FPPE results will be forwarded to the Practitioner for educational purposes.
  - External review may be required in the following circumstances:
    - In quality of care situations when there are no peers with the appropriate expertise who are available and deemed suitable to perform the review; and/or,
    - There is difficulty obtaining a peer who either has or may have the appearance of) a conflict of interest.

#### **FPPE DOCUMENTATION**

All FPPE Evaluation Forms and relevant reports shall be filed in the individual practitioner's credentials file and are considered privileged and confidential in accordance with State Law.

#### **END OF FPPE**

The Ongoing Professional Practice Evaluation monitoring process will begin upon conclusion of the FPPE process.

For low/no volume practitioners who do not utilize the hospital with sufficient frequency to allow for an adequate evaluation of current clinical competence, the practitioner will be responsible for providing alternative information for review that will allow an informed decision regarding the ongoing professional practice evaluation. This may include OPPE data from their primary hospital where they have significant volume relating to the privileges being exercised at WRMC, similar data from a managed care plan, and/or an evaluation from a chief of service and/or peer references specific to the privileges being exercised at WRMC. For office-based practitioners without other hospital privileges, a billing report from their office practice of the types (diagnosis) and numbers of patients seen may also be requested. The peer review committee will make a recommendation to the medical executive committee (MEC) regarding whether the information provided is adequate to establish current competence and for the continuation of privileges.