



# **MEDICAL STAFF RULES AND REGULATIONS**

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## **GENERAL**

1. This document sets forth the Rules and Regulations of the Wadley Regional Medical Center 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 These Rules and Regulations may be adopted, amended, revised, modified, restated and repealed in the manner set forth in the Bylaws.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 nursing service 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. If a dentist or podiatric physician is selected by the patient, an M.D. or D.O. shall be selected to assume the medical responsibility for the patient. 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 Review 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 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 by 3:00 p.m. the day prior to admission. 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 and is assessed daily. 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 involved physician's Department Chairperson.
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 Wadley Regional Medical Center 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. Wadley Regional Medical Center will comply with the Texas 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. A person also may be pronounced dead if the attending physician or designee and a second qualified physician determine that there has been an irreversible cessation of all functions of the brain, including the brain stem (brain death).
16. 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.
17. Southwest Transplant Alliance is notified for all deaths or impending deaths and is the primary contact with the legal guardian for organ donations.
18. Death certificates are the responsibility of the attending physician or designee.

### **CRITICAL CARE UNITS**

1. Admissions and discharges to each unit shall be in accordance with established criteria. Exceptions shall be approved by the Chairman of the Utilization Review Committee, Chief Medical Officer, or the Chief of Staff.
2. The Critical Care Units 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 or other staff physician certified in critical care medicine. The attending physician must make this election when orders to admit a patient to the ICU are given. If the

attending agrees to see the patient within four (4) hours, but fails to do so, the nursing staff is required to contact the hospitalist who shall co-manage the patient for the duration of the stay in the ICU. The hospitalist shall sign off the case at the time of discharge from ICU, unless requested to remain on the case by the attending physician.

## **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, a credentialed ED allied health professional or by a registered nurse in Labor and Delivery. 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 department and/or specialty section will be responsible for developing and implementing their own call schedules and will determine the on-call period (generally one day or week) and the methodology for preparation of the schedule. When there are a sufficient number of physicians in a specialty to cover each calendar day, the department chairperson shall equitably distribute the available days of call between organized group practices and solo practitioners so that group practices with large numbers of physicians are not unduly burdened with call requirements and so each organized practice has the opportunity to regularly participate in the call 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; or
  - c) When the member reaches age fifty-five (55) 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 the appropriate department, 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) If a specialty has 3 or less physicians, each physician is expected to provide at least 6 days of call coverage each month.
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 primary assessment is performed, such as Labor and Delivery, or 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.
  - i) For Labor and Delivery patients the on-call physician must be able to perform emergency C-Sections within 30 minutes of being notified.
7. A physician on specialty medicine call (e.g., cardiology, neurology) may not defer calls to the Internal Medicine Service if the specialist is specifically requested by the Emergency Department physician.
8. In the event the on-call specialist is not readily available, the respective department chair shall be contacted to resolve the problem.
9. 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 physician's Department Chairperson that appropriate disciplinary action should be taken in accordance with the Medical Staff Bylaws.
10. 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.
11. Except in cases where transfer to surgery is contraindicated in the judgment of the attending surgeon, general anesthesia shall not be administered in the emergency treatment area.
12. 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.
13. When the MSE is performed by a registered nurse in Labor and Delivery, the patient may be discharged without face-to-face evaluation by a physician as long as the physician is consulted by telephone and provided with a thorough report of findings. In such cases, the obstetrician must review the medical record of the patient as soon as practical, and at least within 72 hours, and sign-

off on the MSE.

### **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 or surgical treatment; pathologic findings; reports of procedures, tests and results, including operative reports; 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, and pre-operative notes when they have been recorded by a physician's assistant or APRN.
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, Nursing personnel, Physician's Assistants, Dietitians, Physical Therapists, Respiratory Therapists, Speech Therapists, Social Workers, Case Managers, Occupational Therapists, Pharmacists, and Patient Care Technicians.
6. The attending practitioner shall complete the medical record at the time of the patient's discharge, including progress notes, final diagnosis and/or discharge summary. A final progress note including the final diagnosis, discharge medications and follow-up instructions may be completed on patients staying 48 hours or less. Patients staying longer than 48, hours the discharge summary must be dictated within a timely manner. 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. If the discharge summary cannot be dictated at the time of discharge, a final progress note must be written in the medical record, including a final diagnosis.
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 signed 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, written or dictated within 30 days of discharge. On the first of every month, the physician will be notified of all incomplete and delinquent medical records. If the physician has not completed his or her medical records by the 15<sup>th</sup> of the month, 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 the Department of Anesthesiology, the suspension will be in the form of withdrawal of those privileges to give or provide an anesthetic. 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 Chairman of the Department to which he is assigned. 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. Access to medical records of patients will be afforded to members of the Staff for bona fide study and research, gathering relevant statistical information, use in quality improvement activities and other appropriate analysis consistent with preserving the confidentiality of personal information concerning the individual patients. Former members of the Staff will be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the Hospital.
11. All orders for treatment, medications, and diet must be in writing. An order will be considered to be in writing if dictated to authorized personnel and signed by the ordering practitioner. Personnel authorized to record verbal orders include any house staff, allied health professionals, nursing personnel, dietitians, radiology technicians, physical therapists, respiratory therapists, social workers, occupational therapists, speech therapists, case managers, vascular lab techs, and pharmacists. The individual receiving the verbal/telephone order shall immediately enter the order into the medical record, sign 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 orders will not be taken when the physician is on the floor, except in emergency situations or when performing a sterile procedure.
12. 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.
13. 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.
14. Outpatient diagnostic tests or treatments must be documented with an order and diagnosis.
15. All orders will be canceled for a patient when transferred to or from a Critical Care Unit and Surgical Units.

### **SURGICAL CARE**

1. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consent, required laboratory and radiology reports, and consultations, when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the state of surgery) and that the patient's condition is deemed to be satisfactory for the planned surgery. In all other cases the responsible nurse shall notify the operating surgeon, preferably no later than the night before surgery is scheduled, and preparation for surgery including pre-medication shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.
2. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If surgeon fails to show within 15 minutes of the scheduled time of the surgical case, the case will be canceled or the case will be moved to the next available open slot in the schedule. Consistent late arrivals of the surgeon may result in disciplinary action
3. Written, signed, informed surgical consent shall be obtained prior to the operative procedure, except in those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. 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.
4. All patients scheduled for surgery will have a pre-anesthetic or pre-sedation assessment by a qualified physician. The assessment will include the taking of an anesthetic history that includes necessary physical examination; assessment of A.S.A. physical status; formulation of an anesthetic plan; assessment of the patient to make certain that he/she is a candidate for the planned choice of anesthesia; and ordering and/or planning additional testing or consultation. The attending Anesthesiologist in conjunction with a surgeon may require testing or consultation based on ASA class, patient history and anticipated procedure.
  5. The physician or anesthesiologist is responsible for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia and the patient's prior anesthetic history.
  6. Immediately prior to induction of anesthesia or administration of conscious sedation, the patient must be reassessed to assure that administration is appropriate.
  7. The physician or anesthesiologist is responsible for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care which includes at least a description of the presence or absence of anesthesia-related complications, cardio pulmonary status, level of consciousness, and any need for follow-up.
  8. The medical record shall reflect evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
  9. All tissue removed at surgery shall be sent to the hospital pathologist for gross and/or microscopic examination. There is an approved list of "exception" specimens which need not be submitted to pathology. The operative note must accurately describe any specimen removed and not sent to pathology. The pathology report shall be made a part of the patient's medical record. Each specimen shall be accompanied by necessary information including the preoperative diagnosis, description of tissue and brief pertinent clinical data which the surgeon will complete or cause to be completed.
  10. Operative reports shall include the name of the licensed independent practitioner and assistants, procedure(s) performed, estimated blood loss, specimens removed, postoperative diagnosis, a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery when possible, but always within 24 hours post-surgery for outpatients as well as inpatients, and the report shall be promptly signed by the surgeon and made a part of the patient's current medical record. A handwritten post-operative progress note must be recorded immediately after the procedure on all patients undergoing procedures in the operating room, emergency room and radiology. The note should be written by the person performing the procedure.
  11. A staff appointee with provisional privileges that require a proctor or supervision must arrange for and have present his preceptor or qualified assistant for those specified surgical privileges.

**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 Chief Executive Officer. In their absence, the Chief of Staff-elect 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. All anticoagulants, narcotic medications, hypnotics and sedatives will carry an automatic seven (7) day stop order. Ketorolac IV/PO will carry an automatic five-day (120 hours) stop order. All antibiotics and low molecular weight heparins are to be reordered every seven (7) days. All surgical prophylactic antibiotics carry an automatic stop order within 24 hours of anesthesia end time (48 hours for cardiac surgery). Acetaminophen IV has a maximum use of 24 hours. All other medications have a fifteen (15) day automatic stop order. The medical records will be flagged twenty-four (24) hours in advance of the last medication dose. 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 Wadley Regional Medical Center'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 pharmacy 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 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 intraprocedural 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;
- b) The family or the attending physician may request an autopsy;
- c) A provisional gross diagnosis is issued within 72 hours, and the final autopsy report is completed within 60 days;

No hospital autopsy shall be performed without written consent of a relative or legally authorized agent and the request signed by the ordering physician.

2. Each member of the Medical Staff with computer terminal access to WRMC 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 by a physician or allied health professional will result in the following:
  - a) Violations will be reported to the CEO 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;
  
3. Admission of a podiatric patient shall be a dual responsibility of the attending podiatric physician and a physician member of the medical staff. This includes having a qualified physician who is either an admitting member of the medical staff or approved by the medical staff through clinical privileges to perform an admission history and physical examination and record the findings in the medical record. The podiatric physician is responsible for that part of the history and physical examination that is related to podiatry. A physician member of the medical staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of podiatric patients. Podiatric physicians granted the clinical privilege based on training and experience may perform the H&P for their outpatients without medical risk or comorbidity without further requirement of an additional H&P.
  
4. A patient admitted for dental care is a dual responsibility of the dentist and physician member of the Staff.
  - a) Dentist's responsibilities: (1) a detailed dental history justifying hospital admission; (2) a detailed description of the examination of the oral cavity and a pre-operative diagnosis; (3) a complete operative report, describing the findings and techniques; in cases of extraction of teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination, or accurately counted and described in the operative report; (4) the dentist is totally responsible for the oral or dental care; (5) progress notes as are pertinent to the oral condition; and (6) discharge summary. Qualified Oral Surgeons may be delineated the privilege to perform the complete medical history and physical examination at the discretion of the Executive Committee;
  - b) Physician's responsibilities: (1) medical history pertinent to the patient's general health; (2) a physical examination to determine the patient's condition prior to anesthesia and surgery; (3) supervision of the patient's general health status while hospitalized; (4) availability during the performance of a surgical procedure; and (5) physician is not responsible for any dental care or consequences thereof.

Admission and discharge of a dental patient shall be the responsibility of the attending physician, who must be a physician member of the medical staff with appropriate privileges to oversee the general medical care of the patient.

**Resident Supervision Policy:** The attending physician and all faculty members who provide resident supervision at WRMC must be licensed independent practitioners who are members of the medical staff and have been granted clinical privileges through the medical staff process. These clinical privileges must cover every aspect of supervision of the residents. Residents may write orders as outlined in PG 1, PG 2 and PG 3. These orders must be countersigned by the attending or other supervising faculty member at their next visit.

## POST GRADUATE LEVEL I

### Inpatient Service

1. Residents independently obtain medical histories, perform physical examinations, and present it in the medical record.
2. Residents develop a differential diagnosis and diagnostic plan in conjunction with an upper level resident and supervising faculty.
3. Residents select appropriate diagnostic studies in conjunction with upper level resident or supervising faculty. Selection of straightforward, minimally invasive, and low-risk studies (phlebotomy, simple diagnostic imaging, etc.) may be ordered and interpreted independently.
4. Residents arrive at a diagnosis supported by their clinical and laboratory findings and initiate appropriate therapy in conjunction with supervising faculty.
5. Residents may assist medical students in any activity in which they may act independently. As always, the appropriate attending physician is responsible for supervision.
6. As per Federal regulations, PGY 1 residents cannot sign patient restraint orders.

### Invasive and Non-invasive Procedures

1. Resident may perform minimally invasive or low risk procedures (phlebotomy, laceration repair, or removal of central line) independently.
2. Resident may initiate invasive or higher-risk tests or procedures (central line placement\*, neonatal circumcision, thoracentesis, arterial line placement, skin biopsy, lumbar puncture\*\*, I&D abscess, elective intubation, laceration) only in conjunction with the upper level resident or supervising faculty. Performance of the critical portions of the procedure shall occur only in conjunction with the supervising faculty or upper level resident. If an upper level resident is supervising, the upper level resident must have been approved to do the particular procedure in question independently.
3. Emergency intubation may be performed independently in a life-saving effort if the resident has certified in the appropriate life support course (ATLS, NALS, ACLS, or PALS).

Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned level of responsibilities.

\*Central line placement may be performed through the subclavian vein or internal jugular vein utilizing the site right method. Usually, this procedure is done after hours for a patient who has to have venous access and all other options have been exhausted. The resident will be shown both methods in orientation but will perform the internal jugular using the site right method unless there is an absolute contra-indication. Putting in a subclavian vein central line must be approved by the faculty member and recorded in the chart. A procedure note is to be entered into the medical record anytime a procedure is performed. The physician performing the central line placement shall obtain consent from the patient with a nurse as a witness.

**All procedures performed by the first year resident must have on-site supervision.**

## POST GRADUATE LEVEL II

### Inpatient Service

1. Residents independently obtain medical histories, perform physical examinations, and present it in the medical record.
2. Residents develop a differential diagnosis and diagnostic plan in conjunction with supervising faculty.
3. Residents select and interpret appropriate diagnostic studies in conjunction with supervising faculty. Selection of straightforward, minimally invasive, and low-risk studies (phlebotomy, simple

diagnostic imaging, etc.) may be ordered and interpreted independently. More complex, invasive, or higher-risk studies should be ordered and in conjunction with the attending physician.

4. Residents arrive at a diagnosis supported by their clinical and laboratory findings and initiate straightforward disease processes. The supervising faculty is expected to play a dominant role in this process,
5. Residents may assist more junior residents or medical students in any activity in which they may act independently. As always, the appropriate attending physician is responsible for supervision.

#### Invasive and Non-invasive Procedures

1. Resident may perform minimally invasive or lower risk procedures (phlebotomy, removal of central line, skin biopsy, I&D abscess, lumbar puncture, laceration repair), independently.
2. Residents may initiate invasive or higher-risk tests or procedures (central line placement, elective intubation, thoracentesis, arterial line placement, neonatal circumcision) only in conjunction with the supervising faculty.
3. Performance of the critical portions of the procedure shall occur only in conjunction with the supervising faculty and may be performed without faculty presence if the resident has been signed off to do that procedure independently.\*\*\*
4. Residents may independently perform emergency intubation in a life-saving effort if certified in the appropriate life support course (ATLS, PALS, ACLS, or NALS).

Ultimately, it is the decision of the attending physician as in which activities the resident will be allowed to perform within the context of the assigned level of responsibility.

### **POST GRADUATE LEVEL III**

#### Inpatient Service

1. Residents independently obtain medical histories, perform physical examinations, and present it in the medical record.
2. Residents develop a differential diagnosis and diagnostic plan in conjunction with the supervising faculty.
3. Residents select and interpret appropriate diagnostic studies in conjunction with supervising faculty. Selection of straightforward, minimally invasive, and low-risk studies (phlebotomy, simple diagnostic imaging, etc.) may be ordered and interpreted independently. More complex, invasive, or higher-risk studies should be ordered and interpreted in conjunction with the attending physician.
4. Residents arrive at a diagnosis supported by their clinical and laboratory findings and initiate appropriate therapy in conjunction with supervising faculty.
5. Residents may assist more junior residents or medical students in any activity in which they may act independently. As always, the appropriate attending physician is responsible for supervision.

#### Invasive and Non-invasive Procedures

1. Resident may perform minimally invasive or low risk procedures (phlebotomy, removal of central line, skin biopsy, laceration repair, lumbar puncture) independently.
2. Resident may initiate invasive or high-risk tests or procedures (central line placement, elective intubation, neonatal circumcision, thoracentesis, arterial line placement) independently after consultation with the supervising faculty. Performance of the critical portions of the procedure shall occur only in conjunction with the supervising faculty and may be performed without faculty presence if the resident has been signed off to do that procedure independently.\*\*\*\*
3. Residents may independently perform emergency intubation in a life-saving effort if certified in the appropriate life support course (ATLS, PALS, ACLS, NALS)

Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned level of responsibility.

\*\*\*\* The hospital shall be provided the names of the residents and the particular invasive procedures that they have been approved to perform independently. This only occurs after at least 10 procedures (25 for subclavian central lines) have been observed by faculty with privileges in this procedure and the faculty has approved that the procedure can be done independently. For central line placement, 10 procedures for internal jugular central lines or 25 procedures for subclavian central lines must be done to be cleared to do the respective procedure, independently. Internal jugular vein central line placement is preferred unless there is an absolute contra-indication for an IJ central line or supervising faculty wants the central line to be in subclavian vein. Putting in a subclavian vein central line must be approved by the faculty member and recorded in the chart. A procedure note is to be entered into the medical record anytime a procedure is performed. The physician performing the central line placement shall obtain consent from the patient with a nurse as a witness.

### **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 should fulfill routine consult requests within 24 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 must contact the consulting physician personally.
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**

In areas where the performance of any medical staff member is brought to question for clinical or behavioral issues, either through direct observation, documented occurrences in the form of incident reports, letters, or personal communications with officers of the department or chairpersons of committees, an investigative process should be undertaken beginning at the lowest level of authority then progress through the higher

levels of authority as necessary.

Peer Review Defined: *Peer review* differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance rather than appraises the quality of care rendered by a group of professionals to a group of patients. The individual is evaluated by standards of care, and the review should offer constructive criticism of the performance observed. Through this framework, practitioners gain feedback for personal improvement or confirmation of personal achievement related to their effectiveness of professional, technical, and interpersonal skills in providing patient care. Peer Review includes Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

FPPE is a time limited evaluation of a practitioner's competence in performing specific privilege(s). This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high quality care. When a physician joins the Medical Staff, a preceptor will be assigned to evaluate the professional practice of the physician for a specific time frame based on privileges requested and documented competency. FPPE is also implemented to evaluate practitioners in response to concerns regarding the provision of safe, high quality patient care. This may be the result of a trend in adverse medical management or a single serious event in patient management and/or outcome.

OPPE is a documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise or revoke existing privilege(s) prior to or at the time of the two year reappointment cycle. A summary of this data is reported to the Credentials Committee and Medical Executive Committee at least every eight (8) months.

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.

Procedure:

1. Sources for case review are generally identified by both hospital and medical staff through the following mechanisms:
  - a) Hospital-Wide Risk/Quality Indicators (Variance Reports);
  - b) Medical Staff Department Specific Risk/Quality Indicators;
  - c) Outcomes measures that indicate a potential pattern;
  - d) Blood Usage Review;
  - e) Surgical Case Review;
  - f) Drug Usage Review;
  - g) Utilization Review;
  - h) Mortality Review;
  - i) Sentinel Events; and
  - j) Requests for corrective action as described in the By-Laws.
  
2. Triggers resulting in physician peer review include, but is not limited to the following:
  - a) Any unexpected death as delineated in the mortality review criteria
  - b) Unexpected complication(s) in patient condition and/or care or treatment, including those resulting in major permanent loss of function, not related to the patient's natural course of illness or underlying condition
  - c) Complications associated with treatment or procedure
  - d) Post operative complications
  - e) Transfusion reactions (hemolytic, febrile, allergic)
  - f) Patient suicide
  - g) Unplanned readmissions
  - h) Inappropriate transfers to other acute care facilities

- i) Legibility issues
  - j) Department specific triggers as identified by the Medical Staff
3. Once it is determined that a potential quality issue exists, a brief description of the incident/problem/opportunity for improvement is entered onto the peer review sheet by the Clinical Analyst and forwarded to a physician peer reviewer for review.
4. Review is conducted as follows:
  - a) Cases are referred to an individual peer reviewer: a medical staff officer or other active member of the medical staff in good standing who is generally in the same department and/or specialty but has not been involved in the case and does not represent a conflict of interest (e.g. partner of physician being reviewed)
  - b) Cases in which the peer reviewer determines the standard of care was not met, will be referred to the appropriate medical staff department for review
  - c) Cases are assigned and reviewed prior to the meeting
  - d) Reviews may include the referencing of current literature or practice guidelines
  - e) Cases are discussed at the meeting in the presence of all members
  - f) Recommendations and conclusions are made by the committee. Recommendations include assignment of severity level and determination of need for further information or response
  - g) Review should be conducted at the next regularly scheduled meeting of the committee, generally within 90 days of any event (exception: sentinel events shall be reviewed within 45 days). If a review is not completed within 90 days, the Department Chair shall be notified and action shall be taken to facilitate timely review
5. External review may be indicated in the following circumstances:
  - a) External review may be desirable when a committee wishes an independent review when a pattern of practice may be evident, or to receive an independent opinion about the significance of any single event or case
  - b) In specialties where the number of physicians available for peer review is small or review by a staff member may not be possible, it may be necessary to obtain external peer review services for a second opinion or appeal by the reviewer
  - c) External review may only be authorized by a Department Chair or Officer of the Medical Staff
6. Results of peer review discussion shall be recorded in the minutes of that Committee. All peer review documents shall be maintained in the Medical Staff Office. All documents are protected under the federal and state statutes which address peer review. These documents may not be released, reference or reviewed for any other purpose than peer review, including review by the physicians themselves. Peer Review Activities will be included with each reappointment profile and will include the number of cases designated under each outcome level and whether quality issues were identified.
7. Notification of and participation in peer review by Physician
  - a) Participation of the physician: The peer review committee may assign a member to interview the physician, may request the physician attend a meeting to discuss the case(s), or may require a written response.
  - b) Notice by committee:
    - i. Standard of Care Met: no notice required;
    - ii. Standard Not Met: may or may not require a written response. When required, a written response must be submitted within the time specified in the letter. Physicians may provide additional documentation or explanation related to the issue in question. The physician's response (if offered) is considered before the committee makes a final conclusion;
  - c) Penalty: A physician who fails to submit a written response within the specified time to a letter issued by any committee may be subject to the immediate suspension of his/her admitting privileges until such response is received.

- d) Reinstatement of Privileges: Admitting privileges will be reinstated upon receipt of written response to the issue in question. The content of the letter will be considered by the Executive Committee in determining whether or not further action is necessary.
8. To the extent provided by law, the reporting, investigation, communications to, and findings of a medical staff peer reviewer, medical staff committee, or peer review committee is strictly confidential and privileged.