MEDICAL STAFF
RULES & REGULATIONS

12/07/17

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SECTION 1 ADMISSION

1.1 The admission of patients for care and treatment shall be consistent with the official admission policies of the hospital. Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is lawfully authorized to diagnose and admit patients.

1.2 Except in an emergency, no patient shall be admitted to the hospital without a provisional diagnosis. In case of an emergency, or the immediate unavailability of the practitioner, the provisional diagnosis shall be stated as soon after admission as possible.

1.3 Each member of the Medical Staff must comply with applicable federal and state laws including specifically the Consolidated Omnibus Budget Reconciliation Act (COBRA)/Emergency Medical Treatment and Active Labor Act (EMTALA) regulations regarding the evaluation, admission or other disposition of patients presenting to the hospital Emergency Department.

1.4 A Medical Screening Exam (MSE) must be conducted by physicians or Qualified Medical Personnel (QMP) to determine whether an emergency medical condition exists. A QMP is an individual who is licensed or certified and has demonstrated current competence in the performance of the medical screening exam. Emergency medicine Physician Assistants may perform MSE's.

1.5 Practitioners admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatever.

1.6 Each patient shall have a designated "attending physician". Attending physician means the physician who is responsible to coordinate patient care and to collaborate with consultants and the interdisciplinary team to plan care that is appropriate to the patient's needs and severity of illness. The designation of attending may change among consultants during the patient's hospitalization and any such transfer of attending status should be clearly noted in the medical record.

1.7 With the exception of the special care units, there shall be no routine admission laboratory work. The practitioner shall order such tests as are deemed necessary and appropriate.

1.8 Patients admitted to the Critical Care Units must be seen within two (2) hours of admission by the attending practitioner or his/her designate practitioner with the following exception: If the practitioner has examined the patient just prior to admission to the special care unit, the two-hour rule may be waived. In this instance, the practitioner may call the nurse on duty to leave admitting orders and to give a verbal account of the patient's condition or enter admitting orders in the electronic medical record (EMR).

1.9 Obstetrical patients shall not be admitted except under emergency circumstances.

1.10 Physicians are responsible for determining the need for transfer and for implementing arrangements that assure and maintain patient stability and medical condition during transfer.

SECTION 2 DEPARTMENT/COMMITTEE MEETINGS

2.1 **DEPARTMENT OF MEDICINE COMMITTEES:** In addition to the Medical Care Evaluation Committee, ad hoc subcommittees may be appointed by the department chair as the need arises.

2.2 **DEPARTMENT OF SURGERY COMMITTEES:** In addition to the Surgical Care Evaluation Committee, the department of surgery shall have the committees listed below:

2.2.1 Anesthesiology Committee: This committee shall be composed of the members of the anesthesiology section. The Anesthesiology committee chair shall be responsible to the chair of the department of surgery and the surgical care evaluation committee. The committee shall meet at least quarterly.

Anesthesiology shall be a section of the department of surgery and shall ensure that department requirements with respect to the practice of anesthesiology are discharged.

a. All general, spinal and other major regional anesthesia shall be administered by qualified physician anesthesiologists who shall be responsible to the medical staff for complete anesthesia coverage for elective and emergency surgery. A staff anesthesiologist must be present during any procedure requiring a general anesthetic.
b. The anesthesiology committee shall also be responsible for the supervision of the anesthesia recovery room and shall ensure that all anesthesia equipment is maintained in a functional condition.
c. The anesthesiology committee shall ensure that the hospital anesthesia record is complete on each anesthetic administered and that there shall be appropriate pre- and post-anesthesia progress notes in the patient hospital record.
d. Members of the anesthesiology committee shall be available to the medical staff for consultation with respect to difficult or unusual anesthetic problems, diagnostic and therapeutic nerve blocks, airway problems in the unconscious patient, cardiopulmonary resuscitation, and any other problems which relate to anesthesiology.
e. In addition, the anesthesiology committee will assist in the creation and implementation of policies governing the use of sedation, with or without analgesia, by members of the medical staff.
f. Ad hoc subcommittees may be appointed by the department chair as the need arises.

2.2.2 PERIOPERATIVE COUNCIL

The Perioperative Council is an administration-sponsored leadership body which derives its authority from the Medical Executive Committee (MEC). The Council is chaired by the Chief of Surgery and Director of Perioperative Services with support from the Chief Operating Officer. It is based on a collaborative leadership model, with representation from the four groups with vested interest in OR operations: surgeons, anesthesiology, nursing and administration. The Council is empowered to establish strategic vision, set operational priorities, enforce policies and procedures, and sponsor and guide the activities of front-line leadership positions. It controls OR access and operations and oversees Council activity. It accomplishes these tasks through the following committees, each of which reports to the Council:

a. Surgery Scheduling
b. Organizational and Leadership
c. Patient Flow and Case Process
d. Surgical Growth and Development

2.3 **DEPARTMENT OF PSYCHIATRY COMMITTEES:** In addition to the Psychiatric Care Evaluation Committee, the department of psychiatry may have additional committees appointed by the department chair as the need arises.

2.4 **DEPARTMENT OF SPECIAL SERVICES COMMITTEES:** In addition to the department of special services meeting, the department of special services shall have additional committees appointed by the department chair as the need arises.

STANDING COMMITTEES

2.5 Bioethics Committee: This committee shall consist of physicians and such other staff members as the medical executive committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the board of trustees. All members of the bioethics committee shall be voting members.

This committee may participate in development of guidelines for consideration of cases having bioethical implications, including guidelines for advance directives, patient rights and confidentiality; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; the committee will serve in an advisory role affecting consultation with concerned parties, to facilitate communication and education of the medical staff, employees and patient families.

2.6 Cancer Care Committee: This committee shall be composed of physicians from all medical specialties involved in the care of patients with cancer. Included are representatives from oncology, surgery, medicine, diagnostic and therapeutic radiology, and pathology, and there shall also be representation from administration, nursing, social services, quality services, pharmacy and the cancer registry. The committee must also include the Field Liaison Physician to the American College of Surgeons. The committee shall meet at least twice a year.

Duties: The duties of the committee shall be to:

a. Oversee the development of the cancer program
b. Promote cancer education for patients and staff
c. Evaluate the quality of cancer patient care
d. Monitor the activities of the cancer registry

The Cancer Committee is accountable to the Medical Executive Committee through the Special Services Department of the medical staff.

2.7 Committee to Assign Committees: This committee shall be composed of the chief of staff, vice chief, immediate past chief of staff, and department chairs. During election years, both the incoming and outgoing officers and/or department chairs will serve on the committee. The duties of the committee shall be to review the committee membership for both standing and department committees with the exception of the medical executive committee.

This committee will make recommendations to the medical executive committee regarding the committee appointments including the committee chairs. This committee will meet annually after the April quarterly staff meeting.

2.8 Committee on Interdisciplinary Practice: This committee shall include representatives from the active and/or courtesy staffs, administration and nursing. The duties of the committee shall be to monitor and credential allied health professionals. The committee shall meet as necessary and shall report its recommendations to the appropriate department.

This committee shall be composed of equal representatives from the medical staff, the nursing staff, a representative from administration and licensed or certified allied health professionals other than registered nurses who have been granted privileges to perform functions at the hospital. A director of nursing shall be one of the nursing representatives. The physician members shall be appointed by the Medical Executive Committee. The chair of the committee shall be on the active staff. The committee chair may grant temporary privileges to allied health professionals following the procedures outlined in the Medical Staff Bylaws, Article VI, Sections 2, 3 and 4.

Duties: The duties of the committee shall be to:

a. serve as a liaison as needed to the Credentials Committee in matters pertaining to credentialing of allied health professionals;
b. identify functions which are outside the scope of a specific license and therefore require the adoption of standardized procedures;
c. establish written policies and procedures setting forth the required form of each standardized procedure;
d. review and approve all proposed standardized procedures;
e. assume responsibility for identifying and designating individuals who are qualified to practice according to standardized procedures, both on an initial and on a continuing basis;
f. when appropriate insure that the names of those approved to perform functions according to each standardized procedure are on file in the nursing office or at some other designated place;
g. serve as a liaison in matters pertaining to standardized procedures between those approved to perform functions according to standardized procedures at the hospital and the medical staff; and
h. review standardized procedures on an annual basis.

2.9 Continuing Education Committee: This committee shall be composed of one or more members of the departments of medicine, surgery, psychiatry, and special services. The chair shall be a member of the active staff and shall designate a vice chair for continuity purposes. The committee shall include a representative from the quality assessment/improvement committee.

Duties: The duties of the committee shall be:

a. to plan, implement, coordinate and promote programs of continuing education that are designed to keep the medical staff informed of significant developments and skills in medicine and pertinent to the hospital's clinical data in conjunction with research and/or findings of quality assessment and improvement activities. The program planning process shall include:
    i. identification of educational needs of the medical staff;
    ii. formulation of educational objectives for each program;
    iii. evaluation of effectiveness of its programs in meeting the educational objective(s);
b. to maintain a record of educational activities and to submit periodic reports to the medical executive committee;
c. to establish and maintain close liaison with the quality assessment/improvement committee and other medical staff or departmental committees overseeing patient care;
d. to make recommendations regarding the financial needs of the continuing education program as indicated.

2.10 Credentials Committee: This committee shall be composed of active medical staff representing various medical specialties. Committee members are expected to have experience in credentialing and privileging activities. All physicians serving on the committee are expected to attend educational programs. The Chair of the committee shall be a former chief of staff unless otherwise appointed by the Medical Executive Committee.

Duties: The duties of this committee shall be:

a. to review and evaluate the qualifications of each practitioner applying for initial appointment . reappointment , or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate department chairs;
b. submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership, category, department affiliation, clinical privileges and special conditions;
c. investigate, review and report on matters referred by the chief of staff or the Medical Executive Committee regarding the qualification, conduct, professional character or competence of any applicant or medical staff member;
d. to review credentials policies, procedures, forms and clinical privileges criteria and make recommendations regarding same; and
e. submit a credentialing report to the Medical Executive Committee on the status of pending applications, reappointment applications, changes, additions or deletion recommendations.

2.11 Critical Care Committee: This committee shall be composed of members of the active and/or the courtesy staffs, representing both medical and surgical departments. There shall also be representation from administration, nursing services and quality services.

Duties: The duties of this committee shall be:

a. to review and maintain policies and procedures for the critical care units and to recommend new policies and procedures to the medical executive committee;
b. to investigate problems relating to nursing patient care and administration procedures in the critical care/burn units;
c. to review the need for new equipment and supplies and to make recommendations to the Medical Executive Committee for their procurement;
d. to resolve problems concerning the critical care units within the committee, or as necessary, to refer such problems to the Medical Executive Committee; and
e. to review and act on multi-disciplinary performance improvement activities relating to the critical care units.

2.12 Graduate Medical Education Committee: The Graduate Medical Education Committee (GMEC) exists to ensure all medical students, interns and residents (PGY 1 – PGY4) at Saint Francis Memorial Hospital will be properly supervised by qualified medical staff members holding appropriate clinical privileges. The Graduate Medical Education Committee (GMEC) has oversight of the process for the supervision of the professional graduate program(s) at Saint Francis Memorial Hospital.

GMEC Chairperson will meet as needed and provide reports to the Medical Executive Committee (MEC). The MEC will report to the Board of Trustees the activities of the Graduate Medical Education program.

Medical Staff member(s), with appropriate clinical privileges;

a. Shall be appointed for supervision of each participant in the program in carrying out patient care responsibilities.
b. Review and provide written description of the role, responsibilities, and patient care activities of each participant;
c. Provide effective communication with the Medical Executive committee and the Board of Trustees

2.13 Infection Control Committee: This committee shall be composed of members of the active and/or courtesy staffs, including a pathologist, representatives from the departments of medicine and surgery, the infection control coordinator, the director of nursing, the surgery supervisor, and administration representative, as well as representatives from such other hospital departments as are deemed necessary. All members of this committee may vote.

Duties: The duties of this committee shall be:

a. maintaining surveillance over the hospital infection control program;
b. developing a system for reporting, identifying and analyzing the incidence and cause of all infections;
c. developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
d. developing, evaluating and revising preventive, surveillance, and control policies and procedures relating to all phases of the hospital's infection control activities;
e. maintaining a record of all activities relating to infection control and submitting periodic reports thereon to the Medical Executive Committee; and
f. maintaining compliance and educating staff with regard to Occupational Safety and Health Administration regulations.

2.12 Integrated Patient Safety Error Reduction Committee (IPSERC): This Committee is a subcommittee of the QA&I Committee. The purpose of the Integrated Patient Safety Error Reduction Committee (IPSERC) is to improve operational systems through an integrated approach which coordinates activities related to patient safety initiatives and risk management. In addition, the IPSERC provides oversight of the facility's Medication Error Reduction Plan (MERP) and medication safety and error reduction program.

The Committee shall consist of at least two (2) physician members of the QA&I Committee, the Director of Pharmacy, an additional Pharmacist, a Quality Project Analyst, the Director of Emergency Services, the Wound Care RN, the Director of Clinical Informatics, the Director of Critical Care, the Director of Risk Management, the Chief Nursing Officer, the Director of Laboratory Services, the Safety Manager, the Senior Director of Quality and PI, the Radiology Director, and the CMO.

A quorum for taking action shall consist of a minimum of two (2) physician members of the Medical Staff. All members of the committee shall be voting members, except in matters that may relate to physician clinical performance in which voting would be limited to physician members and action would be limited to referral to a peer review committee.

The Committee shall identify opportunities to improve patient and medication safety based upon established goals and analysis of data including, but not limited to:

a. Monitor and evaluate key performance patient and medication safety indicators and make recommendations for improvement;
b. Assign responsibility for and monitor progress of patient and medication safety improvement activities;
c. Make recommendations for improvement related to staff perception of safety;
d. Evaluate and identify areas for improvement related to fostering a culture of safety;
e. Review findings from root cause analyses and provide oversight for corrective action plans;
f. Review Sentinel Event Alerts and make recommendations for related risk reduction strategies;
g. Monitor, evaluate and make recommendations for the reduction of medication errors; and
h. Review and make recommendations related to policies and procedures to improve patient safety.

i. Review blood transfusions for proper utilization, including the use of whole blood versus component blood elements, the amount of blood requested and the amount of blood used, and the evaluation of actual or suspected transfusion reactions.

Regular summary reports will be provided to Quality Assessment and Improvement (QA&I) Committee and Medical Executive Committee (MEC). Additionally, an annual evaluation of the Integrated Patient Safety Error Reduction Program Plan will be submitted by QA&I Committee to the MEC and by the MEC to the Board of Trustees. The annual report shall include the number and types of sentinel events and whether the patients and families were informed of the events, and all actions taken to improve patient and medication safety, both proactively and in response to actual occurrences.

2.13 Pharmacy & Therapeutics Committee: This committee shall be composed of at least five (5) members of the active and/or courtesy staffs and one Pharmacist and one Registered Nurse and one Administrative representative who shall be voting members of the committee. All members of this committee may vote.

Duties: The duties of this committee shall be:

a. to monitor the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital;
b. to advise the medical staff and the hospital's pharmacy department on matters pertaining to the choice of available drugs;
c. to make recommendations concerning drugs to be stocked on the nursing units and by other services;
d. to develop and review periodically a formulary or drug list for use in the hospital;
e. to evaluate clinical data concerning new drugs or preparations requested for use in the hospital;
f. to establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
g. to review adverse drug events;
h. to perform such other duties as assigned by the medical executive committee or chief of staff; and
i. to maintain a record of all activities pertaining to the pharmacy and therapeutics function and submit reports and recommendations to the medical executive committee concerning medication use policies and practices in the hospital.

2.14 Physician Wellness Committee: In order to improve the quality of care and promote the competence of the medical staff, the Medical Executive Committee shall establish a committee on the well-being of physicians comprised of no less than three (3) active members of the medical staff, a majority of which, including the chair, shall be physicians. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

A referral to this committee is made by the Chief of Staff, a Department Chair or Department Subcommittee, the Medical Executive Committee, or a self-referral. Referrals will also be considered from other sources. All referrals to this committee are confidential. This committee does not prescribe disciplinary action.

The Physician Wellness Committee may receive reports related to the health, wellbeing, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern. The committee will monitor the affected physician and the safety of patients until the rehabilitation process is complete. Such activities shall be confidential; however, information may be referred to the practitioner’s department or Medical Executive Committee for corrective action if deemed necessary by the committee members. The committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the Medical Executive Committee, develop educational programs about illness and impairment recognition issues specific to physicians or related activities.

The committee shall meet as often as necessary. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities on a quarterly basis to the Medical Executive Committee.

2.15 Quality Assessment/Improvement Committee: This committee shall be chaired by the vice-chief of the Medical Staff and composed of the chairs of the medical staff departments of medicine, surgery, psychiatry, and special services (or their designate); and representatives from committees with quality improvement responsibilities as indicated. It shall be a multidisciplinary committee including administration, nursing and other professional, technical and support staff. All members of the committee shall be voting members, except in matters relating to physician clinical performance.

This committee shall coordinate the hospital-wide quality improvement program and will function in accordance with the hospital's quality assessment and improvement plan. Key responsibilities include:

a. collaborate with the medical executive committee to plan, develop and implement the Hospital's mission, vision and strategic priorities for quality;
b. participate in identifying priority activities for monitoring and improvement efforts with an emphasis on meeting patient, physician, payer, and community expectations;
c. identify and prioritize resources for large efforts needed to improve processes and outcome of care;
d. serve as the primary committee for oversight of utilization management activities;
e. provide the philosophical framework for hospital-wide performance improvement (i.e. selects the methods to be applied for quality management and organization performance improvement;
f. serve as the primary liaison between the hospital and the regional/corporate quality bodies, regional best practices projects, and regional performance improvement efforts;
g. review on an annual basis and revise as indicated the hospital quality assessment and improvement plan;
h. review reports of quality assessment and improvement activities from all hospital programs
i. and services and prepare a quarterly summary report of organizational performance for review by the medical executive committee and governing body;
j. facilitate organization-wide communication concerning opportunities to improve care, and recommend intervention by administration, departments and/or committees as appropriate; and
k. review and make recommendations concerning risk management activities.

2.16 The Utilization Management Committee (UMC) exists to enhance strategies, methodologies, and operational systems to promote the appropriate and efficient use of resources in delivering patient care services at Saint Francis Memorial Hospital (SFMH).

The UMC shall consist of the Utilization Management Physician Advisor, the Hospitalist Medical Director, a Hospitalist, an Infectious Disease Physician, an Internist, a Surgeon, the Director of Case Management, the hospital Chief Financial Officer, the VPMA, the Chief Nursing Officer and the Director of Health Information Management. There shall also be representation from Risk Management, Inpatient Pharmacy, and Critical Care. The Chief of the Medical Staff and the President/CEO shall serve as ex-officio members.

A quorum for taking action shall consist of a minimum of three (3) physician members of the Medical Staff. All members of the committee shall be voting members, except in matters that may relate to physician clinical performance in which voting would be limited to physician members and action would be limited to referral to a peer review committee.

The Utilization Management Committee evaluates the utilization of resources in the course of patient care, including discharge processes, and oversees the Utilization Management Program Plan. The Committee measures and drives performance, reviews process and outcome measures of utilization practices, and provides oversight of corrective actions to achieve program goals. The Committee may also provide recommendations to staff and physician educational programs and competencies.

The Committee shall identify opportunities to improve utilization based upon established goals and analysis of data including, but not limited to:

a. Inlier Opportunity Index (IOI)
b. Total Average Length of Stay (ALOS)
    a. Top 5 DRG ALOS
    b. Specialty Specific LOS trends

c. Physician Specific LOS trends
c. Avoidable Day Trends
d. Resource Utilization
e. CMS, Joint Commission, State regulatory requirements related to Case Management
f. Recast Inlier Opportunity data
g. Policy and Procedure Approval
h. Denials / Appeals
i. Quality Improvement Organization (QIO) Activities
j. Case Management related Performance Improvement Monitoring System (PIMS) indicators

The UMC shall report performance improvement indicators to the Quality Assessment and Improvement Committee and to the Medical Executive Committee on a quarterly basis.

SECTION 3 CONSENT

3.1 Any proposed invasive treatment or procedure that puts the patient at risk shall be performed only on the signed consent of the patient or his/her legal representative, except in emergencies.

3.2 There must be an informed consent on the chart of any patient undergoing an invasive procedure prior to the onset of the procedure. Such informed consent shall indicate that information about the procedure, its risks and benefits as well as alternative modes of treatment, have been discussed with the patient and family where appropriate.

3.3 Physicians are responsible for informing patients of the risks, benefits and alternatives to the administration of blood and blood products.

SECTION 4 CONSULTATIONS

4.1 Except where consultation is precluded by emergency circumstances, the attending physician shall consult with another qualified medical staff member in all of the following cases: a) all major surgical cases in which the patient is high risk; b) all cases in which the diagnosis is obscure or in which there is doubt as to the best therapeutic measures to be utilized; c) declaration of brain death; d) any patients who have attempted suicide or have taken a chemical overdose; and e) all cases when consultation is required by statute or regulation. That such services were offered shall be documented in the patient's medical record. The chief of staff [or designee] is empowered to request consultation on any patient who, in his/her opinion, warrants it.

4.2 The attending physician must personally contact his/her consultant. Nurses are not allowed to call the consultant.

4.3 The attending physician is responsible for the coordination of care and communication of the plan of care to health care providers involved in care of the patient.

SECTION 5 COVERAGE

5.1 It shall be the responsibility of the attending practitioner or his/her designate practitioner to be available for his/her patient(s) when an emergency arises.

5.2 Each member of the staff shall designate a member of the medical staff who may be called to attend his/her patients in an emergency. In case of failure to name such associate, the chair of the department or the chief of staff shall have the authority to call any member of the staff should he/she consider it necessary.

SECTION 6 DEATHS

6.1 Autopsies shall be performed in accordance with approved criteria developed by the medical staff (refer to medical staff policy, "Criteria for Autopsies"). *(Ref. Doc # 001) <enter document link>*

6.2 Deaths occurring in the operating room or immediately postoperative (within 24 hours) or within 24 hours of admission to the hospital shall be considered coroner's cases.

6.3 No autopsy shall be performed without written consent of a legally responsible person. All autopsies shall be performed by the hospital pathologist or by a practitioner to whom he/she may delegate the duty. In all cases where doubt exists regarding the legal status of death, the coroner shall be notified and a request for autopsy shall be made.

SECTION 7 DISASTER PLANNING

7.1 The plan for the care of mass casualties shall be coordinated with the hospital's Emergency Management Committee. The granting of emergency clinical privileges is detailed in the Medical Staff Bylaws.

SECTION 8 EMERGENCY ROOM CALL

8.1 Physicians on disciplinary monitoring may not be included on the emergency room roster.

8.2 Physicians on call for the emergency room may perform elective procedures or simultaneously take call at another facility. If a patient presents to the emergency room and the on call physician is not available, the on call physician will make a good faith effort to find another qualified physician to respond to the call, failing which the emergency room physician will make every effort to find another physician to accept the patient or the patient will be transferred to another facility. In the event that a transfer is necessary under these circumstances, the on call administrator and chief of staff or designee must be notified.

8.3 Physicians on emergency call are required to respond by telephone to calls from the emergency room within 30 minutes and must be available to respond in person to calls from the emergency room within 60 minutes. Psychiatrists on emergency call are required to respond by telephone within 60 minutes.

SECTION 9 FELLOWS

9.1 At any time, the board of trustees may approve a fellowship program at the hospital.

9.2 Fellows are required to apply for medical staff membership and clinical privileges.

9.3 Fellows may be practitioners in administrative positions as described in Article V, Section 5 of the Medical Staff Bylaws.

SECTION 10 GRADUTE MEDICAL STUDENTS/RESIDENTS

10.1 Saint Francis Memorial Hospital is committed to the education of physicians in training. Members of the Medical Staff are responsible for the supervision and training of medical students and residents. Training/Clinical Rotations programs shall function in accordance with regulations developed by the Graduate Medical Education Committee and the Accreditation Council on Graduate Medical Education.

10.2 Policies and procedures shall be developed to clearly delineate key aspects of the Medical Student and/or Resident training program including, but not limited to supervision, patient care, medical records, due process, and credentialing. Medical students and/or Residents will, at all times, be under the supervision of preceptor/attending physician. The attending physician shall be ultimately responsible for all aspects of patient care. All patient care administered by the resident shall be coordinated with the preceptor/attending physician. Neither medical students nor first-, second-, or third-year medical residents are members of the medical staff and are not entitled to any of the prerogatives of medical staff members.

10.3 Residents may rotated by contractual arrangement between Saint Francis Memorial Hospital and with a teaching facility, in compliance with the regulations of the Accreditation Council on Graduate Medical Education. At all times the residents shall be under the supervision of an attending physician. The attending physician shall be ultimately responsible for all aspects of patient care. All patient care administered by the resident shall be coordinated with the attending physician.

10.4 Residents shall not have admitting privileges or voting privileges nor be a member of the medical staff unless otherwise qualified under Articles III and IV or these Medical Staff Bylaws.

10.5 The descriptions of the role, responsibilities and patient care activities of residents are defined in the Policy on Professional Graduate Education Programs. *(Ref. Doc #002) <enter document link>*

10.6 Residents are subject to periodic evaluation during the course of their rotation. Failure to maintain and comply with standards of professional performance may lead to suspension or termination from the rotation at Saint Francis Memorial Hospital. A resident who faces suspension or termination at Saint Francis Memorial Hospital shall be afforded an opportunity to meet with the Medical Executive Committee. A resident who faces suspension or termination from the accredited teaching program will be afforded due process through that facility's program.

SECTION 11 HISTORIES AND PHYSICALS

11.1 Elements of a history include: date of admission; chief complaint; history of present illness; past history; family and social history; allergies; past medical and surgical history; medication history and review of systems. Elements of a physical examination include: head/eyes/ears/nose/throat (HEENT); cardiovascular; respiratory; abdominal; neurologic, mental status, plus body systems as appropriate for the clinical problem.

11.2 A history and physical examination shall be completed and documented on all cases within twenty-four (24) hours of admission. In specialty units a consultation that includes all of the required elements may be substituted for the history and physical. If a history and physical examination has been performed within thirty (30) days before admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded the medical record in an interval update note documenting an examination addressing the patient's current clinical status and any changes in the patient's condition at the time of admission.

11.3 In all operative cases and invasive treatments or procedures, a history and physical examination and the preoperative diagnosis shall be recorded on the chart before the operation is begun.

If the history and physical examination has been performed within thirty (30) days of the surgery, an interval history and physical examination must also be performed and recorded in the medical record within twenty-four (24) hours prior to surgery. This includes, but is not limited to, hyperbaric treatments, interventional radiology and chemotherapy infusions.

When history and physical examinations are not recorded before the time stated for the operation, the operation and/or procedure shall be canceled, unless the operating surgeon states in writing that such delay would constitute a hazard to the patient.

11.4 Practitioners may utilize a patient's history and physical examination performed by a practitioner who is not a member of the medical staff provided that a practitioner with medical staff privileges at Saint Francis Memorial Hospital:

a. reviews the history and physical examination document;
b. conducts a second assessment to confirm the pertinent information and findings;
c. updates any information and findings as necessary; and
d. signs and dates the information as an attestation to it being current.

SECTION 12 MEDICAL RECORDS

12.1 The attending practitioner shall be responsible for the preparation of a complete medical record of each patient to comply with The Joint Commission's recommendation for hospital records. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray, etc., provisional or working diagnosis, medical and surgical treatment, gross and microscopic findings, progress notes, final diagnosis, condition on discharge, discharge summary for all admissions over forty-eight (48) hours, follow-up and autopsy report when applicable. No medical record shall be filed until it is completed by the responsible practitioner(s).

12.2 Use of CareConnect and Computerized Physician Order Entry (CPOE) is considered part of the routine practice of medicine at Saint Francis Memorial Hospital and as such, is a condition of securing initial privileges and re-credentialing.

12.3 Medical staff members will be trained in the use of CareConnect and CPOE so that they are able to perform the necessary tasks when using the electronic health record.

12.4 All medical staff members are expected to use CareConnect and CPOE in the normal course of care for their patients, and are expected to comply with all the policies and procedures as applicable to CareConnect (i.e. HIPAA privacy regulations, etc.). *

**Exceptions to this rule include Affiliate Staff and Telehealth Consultant Staff and other members who do not enter the facility in the execution of their usual duties or who, in the course of their activities at Saint Francis, are in the facility infrequently.*

12.5 Medical records shall be completed promptly and authenticated or signed by the practitioner within two (2) weeks following the patient's discharge.

12.6 All medical record entries (orders, progress notes, etc.) must be dated, timed and authenticated with the practitioner's signature. Methods of authentication include the practitioner's written or electronic signature. Further, in the rare circumstance that handwritten entries are made, they must be legible to assure effective communication to the healthcare team.

12.7 Discharge orders and instructions are required for all patients except for transfers or death.

12.8 All records are the property of the hospital and shall not be taken away without a court order, subpoena or statute. In cases of readmission of a patient, all previous records shall be available to the attending practitioner, whether the patient be attended by the same practitioner or another.

12.9 Patients must be seen and progress notes recorded at least on a daily basis by the attending practitioner or his/her designate practitioner.

12.10 A treatment or procedure which puts the patient at risk shall be performed only after the provisional diagnosis, indications for the treatment or procedure, and state of the patient's health have been recorded by the physician in the medical record.

12.11 Surgical patients shall have all necessary laboratory test results recorded in the chart before surgery may proceed, as outlined in the Preoperative Patient Preparation Requirements.

12.12 A pre-anesthesia assessment shall be recorded in the medical record prior to the induction of anesthesia or administration of sedation in conjunction with an operative or invasive procedure.

12.13 Immediately following the procedure, a comprehensive note shall be made by the physician. The elements of this note must include the name of the primary surgeon and assistants, procedures performed and description of each procedure, findings, estimated blood loss, specimens removed, and post-operative diagnosis.

12.14 All operations performed shall be fully described in writing, or shall be dictated by the operating surgeon immediately following surgery.

12.15 The operative report may be signed only by the operating surgeon.

12.16 Access to medical records of patients for bona fide study and research will not be granted without approval of the Dignity Health Bay Are Regional Institutional Review Board.

12.17 For acute rehab patients, progress notes are required three (3) times per week by the medical director and the attending physician.

12.18 All transcribed reports must be proofread and corrected prior to being signed.

SECTION 13 OPERATING ROOM

13.1 Surgeons must be in the operating room, ready to commence operating, at the time scheduled. Cases where the operating room is held longer than fifteen (15) minutes may be subject to cancellation.

SECTION 14 ORDERS

14.1 Medications are dispensed and administered only upon orders from individuals granted privileges at the hospital by the medical staff. Verification of privileges must be made through Medical Staff Administration, or through software available in key departments, or through the nursing officer-of the-day.

14.2 Individuals who may prescribe medications include medical doctors, osteopathic doctors, podiatrists, dentists, physician assistants and nurse practitioners operating under standardized procedures. These individuals shall limit their prescribing to those drugs relating to their scope of practice.

14.3 All orders for treatment shall be in writing and must be in compliance with the list of unapproved abbreviations. An order shall be considered to be in writing if dictated to a registered nurse, respiratory therapist, licensed pharmacist, licensed medical technologist, licensed x-ray technician, physical therapist, occupational therapist, social worker, physician assistant, written by such person and signed by the practitioner or covering physician. Verbal orders can only be accepted in emergency situations. Telephone and verbal orders must be read back to the prescriber for confirmation after being written down on an approved form and before being carried out. All orders dictated over the telephone shall be signed by the authorized licensed person to whom dictated and shall include the name of the practitioner who gave the order, the date and time. All such entries shall be authenticated by the ordering or attending practitioner within forty-eight (48) hours.

14.4 Verbal orders for restraint/seclusion shall be authenticated as per the Hospital *<enter document link>*. (Ref. Doc # 003)

14.5 New orders shall be written by the attending practitioner for any patient transferred from general care to a special care unit.

14.6 All current orders must be canceled when a patient goes to surgery or is transferred from a special care unit to general care, and new orders shall be written for continued care.

14.7 Drugs used shall meet the standards of the UNITED STATES PHARMACOPOEIA, NATIONAL FORMULARY, NEW AND NON-OFFICIAL DRUGS, with the exception of drugs for bona fide clinical investigation. Any exceptions must be well justified.

14.8 ANTIBIOTIC DRUG ORDERS: All antibiotic drug orders must be renewed every seven (7) days unless the order indicates the exact number of doses or exact number of days. (Interpretation: Total number of doses specified by number of days, i.e., Ampicillin 500 mg every 6 hours for 7 days = 28 doses).

14.9 I.V. CHEMOTHERAPY: The intravenous administration of antineoplastic agents may be performed by specially trained registered nurses and/or clinical pharmacists under a carefully outlined written procedure.

14.10 OTHER MEDICATIONS: All other medications must be renewed every thirty (30) days by the practitioner.

14.11 Patients shall be discharged only on written or telephone order of the attending practitioner or designate practitioner. The attending practitioner shall state his final diagnosis on the front sheet.

Practitioners agree to abide by the hospital's formulary system, as approved by the Pharmacy and Therapeutics Committee.

SECTION 15 OUTPATIENT SERVICES

15.1 Ambulatory patients being treated under other than local anesthesia shall receive preoperative and post-operative evaluation relative to the procedure performed.

SECTION 16 PEDIATRICS

16.1 Pediatric/adolescent patients are seventeen (17) years of age or younger. Patients who are eighteen (18) years of age and above are considered to be adults.

16.2 Pediatric/adolescent patients may only be admitted to the Bothin Burn Center.

SECTION 17 PROFESSIONAL LIABILITY INSURANCE

17.1 Each practitioner granted clinical privileges (including temporary privileges) shall maintain professional liability insurance in an amount not less than $1,000,000 per occurrence, $3,000,000 aggregate. The insurance shall apply to all patients the practitioner treats and to all procedures the practitioner has privileges to perform in the hospital. The insurance shall provide continuous coverage with appropriate "nose" or "tail" coverage as determined by the Medical Staff.

17.2 Proof of insurance coverage must be provided in the form of current certificates of insurance or confirmation provided by the insurer. The proof shall be maintained in Medical Staff Administration. Information about insurance coverage must be provided at the time of appointment, reappointment, renewal, at the time of any change in coverage, and upon request from any medical staff committee or officer.

17.3 Each member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance or change insurance carrier as soon as reasonably possible to the Medical Executive Committee or Chief Executive Officer, through a notice sent to Medical Staff Administration.

SECTION 18 RESIDENTS

18. 1 By arrangement with other teaching facilities, in compliance with the regulations of the Accreditation Council on Graduate Medical Education, residents rotate to Saint Francis Memorial Hospital. At all times the residents shall be under the supervision of an attending physician. The attending physician shall be ultimately responsible for all aspects of patient care. All patient care administered by the resident shall be coordinated with the attending physician. Residents shall not have admitting privileges or voting privileges nor be a member of the medical staff unless otherwise qualified under Articles III and IV or these medical staff bylaws. The descriptions of the role, responsibilities and patient care activities of residents are defined in the Policy on Professional Graduate Education Programs. *(Ref. Doc # 002) <enter document link>*

Residents are subject to periodic evaluation during the course of their rotation. Failure to maintain and comply with standards of professional performance may lead to suspension or termination from the rotation at Saint Francis Memorial Hospital. A resident who faces suspension or termination at Saint Francis Memorial Hospital shall be afforded an opportunity to meet with the Medical Executive Committee. A resident who faces suspension or termination from the accredited teaching program will be afforded due process through that facility's program.

SECTION 19 RESTRAINT/SECLUSION

19.1 Orders for restraint or seclusion are used only to protect the immediate physical safety of the patient and only when less restrictive interventions are ineffective, and use must adhere to the hospital Restraint and Seclusion Policies. The physician ordering the seclusion/restraints must sign the order within twenty-four (24) hours.

19.1.a Non-behavioral Medical-Surgical restraints:

Orders for non-behavioral medical-surgical restraint(s) must be time limited, not to exceed twenty-four (24) hours, and shall specify the type of restraint to be used and why the restraint is required. The least restrictive form of restraint is used and the order is discontinued at the earliest possible time regardless of the scheduled expiration of the order.

19.1.b Behavioral restraints:

Orders for behavioral restraint(s) must be time limited, not to exceed twenty-four (24) hours, and shall specify the type of restraint to be used (4-point/silicone) and why the restraint is required (e.g., danger to self or to others). For an adult this may not exceed 4 hours. The least restrictive form of restraint is used and the order is discontinued at the earliest possible time regardless of the scheduled expiration of the order.

19.1.c Behavioral seclusion:

Orders for behavioral seclusion (involuntary confinement in a room alone for a period of time) may only be used in the behavioral health unit for violent and self-destructive behavior and for patient or staff safety and the order is discontinued at the earliest possible time regardless of the scheduled expiration of the order.

SECTION 20 UTILIZATION REVIEW

20.1 The attending practitioner is required to document the need for continued hospitalization if requested by the Utilization Management Committee chair or designee. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure to comply with this rule will be brought to the attention of the Medical Executive Committee for action.

SECTION 21 WITHDRAWING/WITHHOLDING LIFE SUPPORT

21.1 A "NO CODE BLUE" order must be documented in the patient's record by the attending practitioner. When the order is written, there shall be a progress note justifying the order.

SECTION 22 MISCELLANEOUS

22.1 No practitioner, whether a member of the medical staff, or a practitioner to whom temporary privileges have been granted, shall be permitted to treat medical or surgical cases or use treatment modalities for which he has not been granted privileges by the respective department.

22.2 No practitioner shall provide "ghost" medical or surgical services, that is, service shall not be provided without the patient knowing the identity of the provider. No practitioner shall engage in fee splitting or other patient referral inducement.

22.3 Any clinical material obtained at Saint Francis Memorial Hospital from either an inpatient or outpatient source shall be processed through the hospital's clinical laboratories, or approved reference laboratories. Clinical material obtained during surgical procedures which are not required to be processed in any laboratory are outlined in the patient care policy on surgical specimens. It shall be the duty of the attending physician to make certain that such pathological diagnosis is incorporated into the medical record. *(Ref. Doc. # 004) <enter document link>*

22.4 Certification in advanced cardiac life support or board certification is required by emergency room physicians. Cardiopulmonary resuscitation training is not required for other medical staff members.

22.5 Physicians must adhere to the Patient Transfer Policy as outlined in the Patient Care Policy and Procedure Manual. *(Ref. Doc. #005) <enter document link>*

22.6 All patients presenting to the hospital (including off-site and satellite clinics), requesting examination or treatment for a possible emergency medical condition, will have a medical screening examination performed by a physician, physician assistant or nurse practitioner.

22.7 Each member of the Medical Staff and Allied Health Professional (AHP) (Except TeleHealth Consultant Staff) must document annual PPD testing and, if PPD testing is positive, must provide documentation of annual tuberculosis screening. In addition, each member shall obtain, or provide documentation of annual influenza vaccination or documentation of declination. Members are required to meet any future federal or state mandated infection prevention testing or vaccinations. Failure to comply with this requirement within thirty (30) days following receipt of written notice from the Chief of Staff shall result in an automatic suspension of the member's clinical privileges and Medical Staff prerogatives. If a member's privileges and prerogatives remain suspended under this section for ninety (90) days, the member shall be deemed to have voluntarily resigned from the Medical Staff.

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