

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I: MEETINGS

- A. The General Medical Staff of the University of Tennessee Memorial Hospital will meet during each calendar quarter of the year. Notice of meeting dates and times will be distributed by the Medical Staff Office.
- B. The time and place of the quarterly meetings may be temporarily changed by the Chief of Staff if deemed advisable for some special purpose.
- C. The place and time of special meetings shall be designated by the Chief of Staff.

ARTICLE II: ADMISSION AND DISCHARGE OF PATIENTS

- A. The Hospital shall accept for care and treatment patients suffering from all types of disease that the Hospital is equipped to care for.
- B. A patient may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.
- C. A Medical Staff member will be assigned as the attending Practitioner having responsibility for the oversight of medical care and treatment of each patient and for communication of pertinent patient information during the course of patient care services and at hand-off of services. An attending Practitioner is responsible for identifying an appropriately credentialed covering Practitioner when the attending Practitioner is not available to provide that care. The Practitioner responsible for the patient at admission will serve as the attending Practitioner until transfer of care is documented. A change in attending service must be documented by transfer order.
- D. Except in emergencies, no patient shall be admitted to the Hospital until a provisional diagnosis or a valid reason for admission has been stated. In case of an emergency such statement shall be recorded as soon as possible.
- E. A patient to be admitted on an emergency basis who does not have a private Practitioner will be seen by the emergency department Practitioner who will refer him to the appropriate member of department or service who will attend the patient.
- F. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the Executive Committee.
- G. The admitting Practitioner will be held responsible for giving such information as may be known to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

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- H. The attending Practitioner is required to document the need for continued hospitalization after specific periods of stay as defined by a departmental medical care evaluation committee and approved by the Executive Committee of the Medical Staff.
- I. Patients shall be discharged by order of the attending Practitioner or designee. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. The patient will be requested to sign a form stating that he is leaving against medical advice.
- J. In the event of a Hospital death, the deceased shall be pronounced dead by the attending Practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to the release of dead bodies shall conform to local law.

- K. Autopsy Policy

The Medical Staff of the University of Tennessee Medical Center recommends offering our autopsy service to the surviving family of any patient dying in our institution. There are certain categories of deaths for which the Medical Staff is advised to order an autopsy with the family's consent. The following categories have been identified:

1. Intra-operative deaths.
2. Death within 24-48 hours of surgery/anesthesia.
3. Rare and unusual diagnostic problems. This includes cases in which the diagnosis is in question or unclear.
4. Death following an unscheduled return to the operating room.
5. Any maternal death.
6. Gynecologic cases without malignancy
7. Death in a short stay patient.
8. Any death which meets Hospital or The Joint Commission criteria as a "Sentinel Event" or which is reportable to the Tennessee State Department of Public Health as an "Unusual Event".

A Hospital pathologist should perform all autopsies with written consent by the next of kin in accordance with state laws.

- L. Deaths Reportable to Medical Examiner.

1. Under Tennessee law, death under any of the following circumstances must be reported to the Medical Examiner for investigation:

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- a. Death from sudden violence or casualty (e.g. firearm injury, sharp force injury, blunt trauma, falls, motor vehicle accidents, and drowning), regardless of the time elapsed from onset of incident to time of death;
 - b. Death by suicide;
 - c. Death occurring suddenly when in apparent good health when the cause of death has not been established by medical diagnosis and/or treatment;
 - d. Death of any person found dead;
 - e. Death occurring in prison;
 - f. Death occurring in a suspicious, unusual or unnatural manner;
 - g. Death when the body is to be cremated;
 - h. Death of a fire victim; and
 - i. Sudden, unexplained death of an infant under one (1) year of age.
2. Members of the Medical Staff should assist the Hospital in reporting to the Medical Examiner for investigation deaths occurring under the following circumstances:
 - a. Inpatient death occurring in a suspicious, unusual or unnatural manner;
 - b. Death of a fetus of 500 grams or more or greater than 22 weeks gestation.
 3. Deaths under the following circumstances, while not required under Tennessee law, to be reported to the Medical Examiner are suggested to be reported based upon recommendation of the National Association of Medical Examiners.
 - a. Death when not under the care of a physician for a potentially fatal illness;
 - b. Death related to an overdose of illicit drugs, alcohol or legal medications;
 - c. Death occurring on the job or related to employment;
 - d. Death believed to present a public hazard.
- M. In accordance with Tennessee' Revised Uniform Anatomical Gift Act and applicable federal law and regulations, all acute care hospitals are required to develop policies and procedures to ensure the routine referral of all deaths and impending deaths to their regional organ procurement organization (OPO) for the determination of medical suitability for organ and tissue donation. Tennessee Donor Services (TDS) is the designated OPO for UTMC. Members of the Medical Staff should follow the UTMC *Organ and Tissue Donation Policy* and *Organ Donation – Donation after Cardiac Death Policy*. These policies assure that all potential organ and tissue donors are identified and families are provided the option of donation in compliance with the law.

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N. Categorical Exemptions Authorized by the Medical Staff

Categorical exemptions from pathology review authorized by the Medical Staff shall be as follows:

In compliance with Hospital Policy and with provisions of The Joint Commission which allow certain exclusions, we will exclude from sending to Pathology the following specimens: cataracts, teeth, orthopedic appliances, foreign bodies, portion of rib removed only to enhance operative exposure, foreskin from circumcision of newborn infants, placentas that are grossly normal, saphenous veins used for various vascular bypass procedures, and grossly normal tissue or scar tissue, excluding breast tissue, removed solely for cosmetic purposes. Exemptions are also to include any organs or tissue removed for the purpose of organ transplantation and/or tissue banking.

All bullets are to be sent to the security office and will be signed for by the receiving officer.

ARTICLE III: MEDICAL RECORDS

A. General

1. All medical records are the property of the Hospital and shall not be removed from the premises except by court order, subpoena, statute, or special permission by the Hospital Administrator.
2. Effective October 1, 2007, the permanent medical record shall be the compilation of electronic records comprised of:
 - a. The optical imaged medical record where paper records are scanned and maintained by the Medical Records Department;
 - b. The electronic QS (Quantitative Sentinel System), for mothers and well babies, where entries are made directly into the system and maintained by the Labor & Delivery Department;
 - c. The Cerner PowerChart system where entries are made directly into the system by clinical staff, and maintained by the Information Systems Department.
3. Upon proper request, a patient record may be made available for viewing on a computer workstation or reproduced by the printer.
4. Written consent of the patient or his legal representative is required for the release of medical information to persons not otherwise authorized to receive this information.

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5. The attending Practitioner shall be responsible for the preparation of a complete medical record on each patient. A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including appropriate dates. This record should generally include identification, data, complaints, personal history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, radiology, and others, provisional diagnosis, medical and/or surgical treatment, pathological findings, progress notes, final diagnosis, condition at discharge, summary, and where applicable, follow up and autopsy reports.
 6. A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Medical Records Committee.
 7. Only authorized individuals may make entries in the medical record. Authorized individuals include UTMH credentialed staff, UTMH employees involved in treatment of the patient and other appropriately qualified individuals involved in the care of the patient.
- B. Suspension
1. Weekly notification, including a listing of all incomplete records will be provided via facsimile, e-mail or hand delivered to each Practitioner's office.
 2. The suspension list will be generated daily. Practitioners who will have a record become delinquent (incomplete greater than 30 days post discharge), will be contacted by the Medical Records Department staff at least 24 hours prior to the record becoming delinquent.
 3. If the deficiency has not been completed by the 30th day post discharge, the Practitioner will be suspended from admission, consultation and operative privileges by the Chief of Staff until delinquent records are completed.
 4. The Practitioner may submit a written petition to the Chief of Staff for a delay in suspension under this section. Such petition shall be considered solely in cases where failure to complete records is due to a circumstance wholly outside the control of the Practitioner. Such delay may be for a period of no greater than 7 days and may be granted only by an affirmation vote of a committee comprised of the Chief of Staff; the Chair of the Credentials Committee and the Chair of the Medical Records Committee.
 5. In the event a Practitioner has three (3) consecutive suspensions or four (4) suspensions within six (6) months, the Medical Record Committee will

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automatically refer the case to the Credentials Committee for consideration of summary suspension.

C. Housestaff

On those charts where housestaff is responsible for entries in the medical record, a responsible member of the Medical Staff shall be responsible for countersigning the operative report, discharge summary, and history and physical.

D. History and Physical Examination

1. A history and physical examination must be recorded within 24 hours after admission and/or prior to an operative and/or invasive procedure. If a complete history and physical examination has been performed within 30 days prior to admission or registration, a legible copy of this report signed by the attending Practitioner may be used in the patient's Hospital medical record. In the event such report is used, the attending Practitioner must perform an updated examination. Such updated examination, along with the patient's current status and/or any changes in the patient's status since the previous history and physical, must be documented by the Practitioner. This note must be dated within 24 hours after admission. All medical history and physical examinations shall be completed by a Physician member of the Medical Staff or by an oral and maxillofacial surgeon who has been granted Type I privileges in the Department of Oral and Maxillofacial Surgery. In addition, for dental patients, the responsible dentist must record the dental portion of the history and physical examination. In accordance with state law, allied health professionals and dependent professionals, as defined under these Bylaws, may perform all or part of the medical history and physical examination, if granted such privileges.
 - a. The comprehensive or detailed history and physical examination for inpatient and observation patients must contain the following information:
 - i. chief complaint
 - ii. history of the present illness
 - iii. pertinent past, social and family history
 - iv. relevant review of systems
 - v. pertinent physical examination
 - vi. statement of the conclusion or impressions
 - vii. statement of the course of action planned for the patient while in the Hospital
 - b.
 - i. A minimum of a problem-focused history and physical examination shall be required for all:

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- (a) ambulatory patients having procedures in the operating room; and
 - (b) patients having an ambulatory procedure and who receive anesthesia or sedation other than local anesthesia.
- ii. A problem-focused history and physical examination must contain the following information:
 - (a) chief complaint
 - (b) brief history of present illness or problem
 - (c) pertinent system review
 - (d) physical examination of affected body area or organ system and other symptomatic or related organs
- c. In all cases (inpatient or outpatient) for which operative and/or invasive procedures are planned, pertinent diagnostic tests and a pre-operative diagnosis, in addition to the medical history and physical examination, as outlined in Section D.1. above, must be documented in the medical record prior to the procedure. When all these elements are not documented, the procedure shall not proceed until the deficit is corrected or unless the attending Practitioner states in writing that such delay will be detrimental to the patient.

E. Consultation

A consulting Practitioner should write orders when requested to do so by the attending Practitioner or in urgent/emergent patient care situations. Consultation should show written evidence of the review of the patient's records by the consultant, pertinent findings, the consultant's opinion and recommendations. Practitioners serving as consultants are responsible for identifying a covering Practitioner when they are not available to provide that care. A consultant is responsible for communicating pertinent patient information during the course of patient care services and at hand-off of services.

F. Operative Reports

- 1. All operations and invasive procedures must be fully described by the procedure practitioner and authenticated by the attending procedure practitioner. The operative and/or procedure report must be recorded immediately after the procedure. As the dictated report is not immediately available, the procedure practitioner must record the required information in the progress notes.

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2. Operative reports should contain the following information:
 - a. Name of licensed independent practitioner and assistants
 - b. Procedure(s) performed and description of procedure
 - c. findings
 - d. estimated blood loss
 - e. specimens removed
 - f. postoperative diagnosis
- G. Progress Notes and Orders
1. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Such notes should be legible, timed, dated, authenticated in accordance with Medical Staff Policy and Procedure regarding authentication of clinical entries / numerical identifiers and should be written at least daily by the Practitioner.
 2. All clinical entries in the patient's medical record should be accurately timed, dated and authenticated in accordance with Medical Staff Policy and Procedure regarding authentication of clinical entries / numerical identifiers.
 3. Symbols and abbreviations on the Hospital's unapproved abbreviations list shall not be used in the medical record.
 4.
 - a. Verbal orders should be used as infrequently as possible. Verbal orders shall be documented in the patient's medical record and must be legible, timed, dated and authenticated. Verbal orders shall be reviewed and countersigned by the ordering practitioner at that practitioner's next visit to the patient or within 48 hours of the verbal order. A practitioner who is providing coverage for a practitioner who has given a verbal order may review and countersign the verbal order of the practitioner to whom coverage is being provided.

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- b. Verbal orders for patient restraints shall be authenticated within twenty-four (24) hours of the verbal order.
- c. Verbal orders should be used only to meet the urgent care needs of the patient when it is not feasible for the ordering practitioner to immediately communicate the order in written or electronic form.
- b. Verbal orders will not be accepted for chemotherapy agents and medications administered via intrathecal or intraventricular routes.
- c. Except as follows, verbal orders will be accepted and recorded in the medical record only by registered nurses or licensed practical nurses. Each of the following orders shall be checked off promptly by a member of the nursing staff.
 - i. permission granted to admission clerks to take orders for outpatient plain x-rays and lab procedures;
 - ii. permission granted to dietitians to record from the doctor any verbal orders relating to nutritional care;
 - iii. when it is expeditious in the case of a patient, appropriately credentialed Respiratory Therapists and Respiratory Therapy Technicians shall be authorized to take verbal and telephone orders and record them in the medical record;
 - iv. pharmacists are authorized to accept verbal or telephone medication orders and medication-related orders from members of the Medical Staff. Such orders will be reduced to writing in the patient's chart in accordance with the established procedures for verbal orders;
 - v. permission granted to physical therapists, occupational therapists, speech-language pathologists, and audiologists to record from the Practitioner any verbal or telephone orders relating to rehabilitation care.

H. Discharge Summary

- 1. The discharge summary should be recorded at the time of discharge of the patient and must be recorded within 30 days of the patient's discharge. A final diagnosis should be recorded in full at the time of discharge of the patient, using an acceptable terminology.
- 2. The discharge summary should include the following:
 - a. final diagnosis

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- b. the reason for hospitalization
 - c. significant findings
 - d. procedures performed and treatment rendered
 - e. condition of the patient at discharge
 - f. instructions given to the patient and/or family as pertinent
3. A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetric deliveries. Final progress notes should include:
- a. final diagnosis
 - b. procedures performed
 - c. condition at discharge
 - d. discharge instructions
 - i. activity / restrictions
 - ii. diet
 - iii. discharge medications
 - iv. follow up
4. When an autopsy is performed, the provisional anatomic diagnosis should be recorded within 3 days. The complete autopsy should be filed in the medical record within 90 days.

ARTICLE IV: GENERAL CONDUCT OF CARE

- A. A general consent form signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. A specific consent form should be obtained prior to any special treatment or surgical procedure.
- B. Only Physicians, Dentists and others authorized under the Medical Staff Bylaws and Medical Staff Rules and Regulations may issue patient care orders. All orders for treatment shall be in writing. A verbal order should be considered in writing if dictated to a duly authorized person functioning within a sphere of confidence and signed by the responsible practitioner. A verbal order shall be transcribed by the person authorized to receive such order and contain the name

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- of the issuing practitioner and signature of the person receiving such order. The responsible practitioner shall authenticate such order.
- C. The practitioner's orders which are illegible will not be carried out until understood by the individual responsible for executing the order.
 - D. Medication orders will be reconciled by the responsible practitioner when patients go to surgery. All other previous orders are cancelled.
 - E. All drugs and medications administered to patients shall be those listed in the latest edition of the U.S. Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions.
 - F. The attending Practitioner is primarily responsible for requisition of a consultation when indicated. When the attending Practitioner's delineation of Clinical Privileges does not include a service required by a patient for whom the Practitioner is the attending Practitioner, a consultation from a Practitioner with those privileges should be requested.
 - G. All patients admitted to general medical and/or surgical adult and pediatric intensive care units ("ICUs") and other ICUs designated by the Medical Staff will have a board certified intensivist as an attending-of-record or as a consultant, collaborating in the management of the ICU patients. When the intensivist is the attending, the patient's primary care Practitioner and/or the responsible surgeon or sub-specialist Practitioner(s) will be automatically notified or consulted as appropriate to participate in the care of the patient.
 - H. Practitioners who participate in clinical research that includes inpatient admission as a part of any investigational protocol must have the study approved by an institutional review board (IRB) listed upon the Federal Wide Assurance (FWA) of the Hospital currently on file with the United States Office for Human Research Protections prior to initiation of inpatient care under the protocol. A copy of the protocol must be on file with the IRB and a copy of the IRB approved clinical research consent form must be placed in the Hospital chart (record). For patients admitted to the Hospital, who are on a non-FWA listed IRB approved clinical research protocol and who will have a portion of the research performed during the admission, a copy of the patient's specific clinical research consent form must be placed in the Hospital chart (record) upon admission.
 - I. An appropriately skilled registered nurse, functioning within his or her scope of practice under State law and under an approved protocol in Labor & Delivery, may provide triage and medical screening to the pregnant patient as a qualified medical professional as that term is defined by Emergency Medical Treatment and Active Labor Act (EMTALA)

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ARTICLE V: CARE OF EMOTIONALLY ILL PATIENTS IN THE HOSPITAL

- A. When a patient is identified as suffering from an emotional or psychiatric illness in the Hospital, there are several options available to the attending M.D.:
1. Depending on the severity of the illness/situation, the attending Practitioner may choose to provide the necessary treatment for the patient.
 2. A consultation may be obtained from a psychiatrist, psychologist or other appropriate mental health professional practicing at Hospital. Such consultant will assist the attending Practitioner in managing the illness while the patient is in Hospital or can assist by recommending an alternative treatment/facility to better manage the psychiatric or emotional illness.
 3. For patients deemed dangerous to self or others, a consultation may be obtained as noted in Item (b) and/or from mobile crisis unit to screen for transfer via commitment to Lakeshore Mental Health Institute or Peninsula Hospital. This will require a Practitioner's completing an emergency commitment form in order to enact the transfer if approved by the mobile crisis unit.

ARTICLE VI: MEDICAL STAFF CODE OF CONDUCT POLICY

- A. The Medical Staff believe that all individuals within the Hospital should be treated courteously, respectfully, and with dignity. To that end all individuals, employees, Practitioners, and other dependent practitioners will conduct themselves in a professional and cooperative manner in the Hospital. This policy is intended to address conduct of Practitioners which is directed at patients, families, nurses, Hospital personnel, Practitioners or any other person in the Hospital.
- B. In establishing a general framework for appropriate and inappropriate behavior within the Hospital, the following general goals of conduct and/or behavior should be recognized and emulated. The Medical Staff believe that those addressed by this policy should:
- Work together with patients and other members of the healthcare team in such a manner that integrity, commitment, compassion, and caring are observed by all;
 - Engage, listen and clearly explain issues to patients in a manner that will exceed the patients' expectations;
 - Earn the loyalty of patients, colleagues and staff through appropriate behavior and interaction;
 - Influence and communicate with patients, families and all members of the healthcare team in a positive and cooperative way;

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- Look for exemplary behaviors in others, emulate and share those behaviors with patients and others to improve both the experience of patients and the perception of the Hospital to patients, primary and specialty care physicians and the community;
 - Discuss differences in approaches to care in a setting and manner which will facilitate improvement of care and which will avoid disruption of care.
- C. Within the rubric of the general goals outlined in Section B above and for purposes of this policy, “appropriate conduct” includes, but is not limited to:
- Treating patients, staff, physicians and other colleagues and all others in the Hospital with dignity and respect;
 - Establishing and maintaining effective communication with patients, their families/caregivers and all other members of the healthcare team;
 - Listening to the input of other members of the healthcare team and actively implementing positive changes as a result of such input;
 - Promptly and professionally responding to calls, pages, and consults;
 - Communicating effectively with staff, physicians, Practitioners and all members of the healthcare team in order to enhance continuity and quality of care, including conducting hand-off of patient care responsibilities and consultation such that Practitioner-to-Practitioner communication is facilitated;
 - Acting in recognition of the Hospital’s mission of teaching and learning from each other in all interactions with Hospital staff, including residents and fellows;
 - Treating all members of the healthcare team in a way which we would want to be treated;
 - Completing medical records in a timely and legible manner consistent with the requirements of the Medical Staff Bylaws, Rules and Regulations and assuring that all documentation is provided to support coding requirements;
 - Maintaining and posting a current and accurate “on-call” schedule, including the name of the on-call Practitioner and all contact information;
- D. Inappropriate Conduct
1. This policy is also intended to address conduct which does not meet the general goals and standards of appropriate conduct as described above. In dealing with incidents of inappropriate conduct, the protection of patients, employees, Practitioners, and others in the Hospital and the orderly operation of the Hospital are paramount concerns.
 2. It is acknowledged that a hospital setting presents an especially stressful working environment. Accordingly, outbursts or other misconduct that would not be tolerated elsewhere are often excused. There are clearly limits to such tolerance. When a Practitioner’s conduct disrupts the operation of the Hospital; is directed at patients, families or others; affects the ability of Hospital employees, Practitioners on the Medical Staff or

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others to get their jobs done; compromises patient safety; or begins to interfere with the Practitioner's own ability to practice competently, action must be taken. For purposes of this policy, the definition of "inappropriate conduct" includes, but is not limited to:

- Threatening, intimidating or abusive language or threatening another individual); conduct
 - Degrading, disrespectful, rude or demeaning comments or actions
 - Profanity or similarly offensive language
 - Physical contact that is threatening, intimidating or inappropriate
 - Physical abuse or assault
 - Violent actions and behaviors
 - Public comments which violate state or federal statutes, regulations or are unprofessional
 - Inappropriate medical entries and written or verbal comments about the hospital or others who work or practice at the hospital
 - Sexual harassment or misconduct
 - Refusing to perform responsibilities as defined by the Medical Staff Bylaws, Rules and Regulations
 - Uncooperative attitudes and actions
 - Misuse of Practitioner contact information
3. Conduct that may constitute sexual harassment shall be addressed pursuant to the Hospital's sexual harassment policy.
 4. Employees and Practitioners should not collaborate, perpetuate, and/or enable disruptive behavior by their actions or inactions. Employees and Practitioners may report disruptive behaviors without fear of retaliation.
 5. This policy outlines collegial steps (i.e., warnings and meetings with a Practitioner) that can be taken in an attempt to resolve complaints about inappropriate conduct exhibited by Practitioners. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and which requires immediate disciplinary action. Therefore, nothing in this policy precludes immediate referral to the Executive Committee for investigation pursuant to the Medical Staff Bylaws or the elimination of any particular step in the policy in dealing with a complaint of

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inappropriate conduct.

- E. Procedures for Addressing Inappropriate Conduct
1. Hospital staff who observe, or are subjected to, inappropriate conduct by a Practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the Chief Administrative Officer. Any Practitioner who observes such behavior shall notify the Chief Medical Officer and/or Chief of Staff directly. Reports by patients or other persons of such behavior shall be documented and forwarded to the Chief Medical Officer or Chief of Staff. Upon learning of the occurrence of an incident of inappropriate conduct, the individual to whom the conduct was reported shall request that the individual who reported the incident to document the incident in writing. In the alternative, the individual to whom the conduct was reported should themselves document the incident as reported.
 2. The documentation shall include:
 - a. The date and time of the behavior at issue;
 - b. A factual description of the behavior at issue;
 - c. The name of any patient or patient's family member who witnessed the incident;
 - d. The names of other witnesses to the incident;
 - e. The circumstances which precipitated the incident;
 - f. Consequences, if any, of the inappropriate conduct as it relates to patient care, personnel, or Hospital operations; and
 - g. Any action taken to intervene in, or remedy, the incident.
 3. The individual documenting conduct reported under this policy shall forward a documented report to the Chief Medical Officer or the Chief of Staff within three (3) working days. A Review Committee, functioning as a sub-committee of the Medical Wellness Committee and consisting of two of the three following individuals (the Chief Medical Officer, the Chief of Staff and the Chairman of the Medical Wellness Committee, or their designees), shall meet and discuss the report, and may meet with the individual who submitted the report and/or witnesses to the incident to ascertain the details of the incident. The Review Committee will confirm or refute the report of inappropriate conduct and, when valid, assign a level of non-compliance based upon the guidelines for assessing and

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correcting inappropriate conduct as set forth below in this paragraph 3. All documentation generated by the activities of the sub-committee shall be filed in the Practitioner's peer review file.

The Review Committee referenced in this paragraph 3 shall utilize the following rubric for assessment of conduct under this Policy and the corrective action associated with such conduct.

- a. **Levels of Non-Compliance in Conduct**
 - i. **Level One** These actions are unintentional or as a result of interactions while intending to be compliant.
 - ii. **Level Two** These actions are as a result of the departure from acceptable behavior as result of the failure to recognize the significance of the interaction or the mistaken belief that the behavior was somehow justified.
 - iii. **Level Three** These actions are as a result of intentional actions which the Review Committee believes are unacceptable to the Medical Staff at-large, a violation of law, or as a result of a persistent failure to comply with this Medical Staff Code of Conduct.
- b. **Levels of Corrective Actions**
 - i. **Level One** A violation confirmed by the Review Committee will be addressed by the Chief Medical Officer or Chief of Staff with the offending practitioner. The focus will be education regarding future interactions.
 - ii. **Level Two** A violation confirmed by the Review Committee will be addressed by the Review Committee and appropriate Service Chief with the offending practitioner. The focus will be discussion of the violation, education and documented warning to correct future interactions.
 - iii. **Level Three** A violation confirmed by the Review Committee will be addressed as set forth in Section F below.

- F. In the event that conduct is found by the Review Committee discussed in paragraph E.3 above, to warrant a Level Three designation, or for such other conduct as the Review Committee may deem appropriate, the following steps will be followed.

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1. Four members of the Service Chief's Committee will be assigned by the Chief of Staff and/or the Chief Medical Officer to meet with the Practitioner. This team shall include two chairs to include the Practitioner's respective department chair and one additional, an administrative representative, and a third member who is a Practitioner from the service chief's committee. This initial meeting shall be collegial. It is designed to be helpful to the Practitioner in understanding that certain conduct is inappropriate and unacceptable. During the meeting, the Practitioner shall be advised of the nature of the incident that was reported and shall be requested to provide his/her verbal or written response and/or perspective concerning the incident. The Practitioner shall also be advised that, if the incident occurred as reported, his or her conduct was inappropriate and inconsistent with standards of the Hospital. The identity of the individual preparing the report of inappropriate conduct will not be disclosed at this time, unless the team agrees in advance that it is appropriate to do so. In this case, the Practitioner shall be advised that any retaliation against the person reporting the incident will be grounds for a formal investigation pursuant to Article VIII and any other appropriate sections of the Medical Staff Bylaws will be initiated.
2. This initial meeting can also be used to educate the Practitioner about administrative channels that are available for registering complaints or concerns about quality or services. Other sources of support or counseling can also be identified for the Practitioner, as appropriate. A copy of this policy, along with an information sheet regarding inappropriate conduct, will be provided to the Practitioner at this meeting.
3. The Practitioner shall be advised that a summary of the meeting will be prepared and a copy provided to him or her. The Practitioner may prepare a written response to the summary. The written summary and any response that is received shall be kept in the Practitioner's confidential performance improvement file. Substantiated behavior-related events shall be considered during the biennial reappointment process.
4. If another report of inappropriate conduct involving the Practitioner is received, a second meeting shall be held. The previously identified team will be present to meet with the Practitioner. At this meeting, the Practitioner shall be informed of the nature of the incident and be advised that such conduct is unacceptable. The Practitioner shall be advised that if there is a future complaint about inappropriate conduct, the matter will be referred to Medical Staff Executive Committee (MEC) for more formal action. A letter shall be sent to the Practitioner confirming the substance of the meeting, a copy of which shall be kept confidential in the Practitioner's performance improvement file (along with any response that the Practitioner may submit). A second copy of this policy, and a second

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copy of an information sheet regarding inappropriate conduct, will be provided to the Practitioner along with this letter.

5. In the event there is a third substantiated incident, a third meeting shall be held. The purpose of this meeting is to provide the Practitioner with a final warning that the inappropriate conduct will not be tolerated.
6. Following this meeting described in Paragraph F.5, a letter shall be sent to the Practitioner. The letter shall describe the inappropriate conduct, outline the steps that have been taken in the past to correct that conduct, and detail the kind of behavior that is acceptable and unacceptable. The letter should also confirm the consequences of an additional incident of inappropriate conduct. A third copy of this policy, and a third copy of an information sheet regarding inappropriate conduct, will be provided with this letter.
7. The letter described in Paragraph F.6 will define the conditions of continued practice at the Hospital. The Practitioner shall be required to sign it. If the Practitioner refuses to sign the letter, the Chief Medical Officer and/or Chief of Staff shall request that a formal investigation be, pursuant to Article VIII and any other appropriate sections of the Medical Staff Bylaws, commenced within thirty (30) days.
8. A single additional incident (i.e., a fourth substantiated incident) shall then result in the referral of the Practitioner for a formal investigation pursuant to Article VIII and any other appropriate sections of the Medical Staff Bylaws. The Practitioner will be notified of this referral by a certified and/or registered letter.
9. In order to effectuate the objectives of this policy, and except as otherwise may be determined by the Chief Medical Officer and the Chief of Staff, Hospital counsel or the Practitioner's personal counsel shall not attend any of the meetings described above.

ARTICLE VII: ADOPTION AND CERTIFICATION

These Rules and Regulations were adopted and restated in their entirety by the Medical Staff on the 16th day of August, 2011, and by the Governing Body on the 26th day of October, 2011 and include all amendments through the meeting of the Governing Body of October 26, 2011.