

RUSH UNIVERSITY MEDICAL CENTER
RULES AND REGULATIONS
OF THE MEDICAL STAFF

Approved by the Executive Committee and Rush University Medical Center
Of the Medical Staff on November 7, 1986

Further Amended on:

12/10/92
11/10/94
01/12/95
08/08/96
09/12/96
12/12/96
11/13/97
02/12/98
06/11/98
09/10/98
10/08/98
04/08/99
07/15/99
08/12/99
10/14/99
11/08/01
11/14/02
10/02/03
11/06/03
10/07/04
02/03/05
04/07/05
01/12/06
03/02/06
04/06/06
05/04/06
03/01/07
02/05/09
10/01/09
11/05/09
01/07/10
09/01/11
01/05/12
06/15/12
02/11/14
11/09/15
03/04/16
05/14/18

TABLE OF CONTENTS

	Page
I. MEDICAL STAFF CODE OF CONDUCT AND PROFESSIONAL BEHAVIOR	1
II. GENERAL CONDUCT OF CARE.....	4
A. ADMISSION AND DISCHARGE OF PATIENTS.....	4
B. CONSENTS.....	8
C. PATIENT CARE PROVISIONS.....	10
D. SUPERVISION OF RESIDENTS.....	12
E. Emergency Services.....	13
F. SPECIAL CARE UNITS.....	14
G. CLINICAL DEPARTMENTS.....	14
H. MEDICAL STAFF MEETINGS	14
I. STAFF POLICIES	14
J. BLOOD-BORNE PATHOGEN AND TB/INFECTION CONTROL (OSHA) TRAINING REQUIREMENTS.....	14
K. DISRUPTIVE CONDUCT POLICY FOR MEDICAL STAFF MEMBERS.....	15
III. HEALTH INFORMATION MANAGEMENT/MEDICAL RECORD RULES	18
A. MEDICAL RECORD DOCUMENTATION FOR PSYCHIATRIC SERVICES – RESTRAINTS	29
B. MEDICAL RECORD DOCUMENTATION FOR PSYCHIATRIC SERVICE –SECLUSION.....	29
C. MEDICAL RECORD – ELECTRO-CONVULSIVE THERAPY (E.C.T.).....	29
D. CONFIDENTIALITY OF RECORDS	29
IV. MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT RULES	37
A. GENERAL POLICY & PROCEDURE.....	37
B. TEMPORARY PRIVILEGES	39
C. TEMPORARY PRIVILEGES FOR SPECIFIC PATIENTS	39
D. DISASTER PRIVILEGES.....	40
E. EMERGENCY PRIVILEGES.....	40
F. TELEMEDICINE	40
G. RULES FOR RESIDENTS PERFORMING NON-SUPERVISED ACTIVITIES (OUTSIDE SCOPE & DUTIES OF RESIDENCY TRAINING PROGRAM) AS INDEPENDENT PRACTITIONERS AT RUMC.....	40
V. HEARING RULES.....	41
VI. DEFINITIONS.....	50

I. MEDICAL STAFF CODE OF CONDUCT AND PROFESSIONAL BEHAVIOR

Professional behavior, ethics and integrity are expected of each individual member of the Medical Staff at Rush University Medical Center. This Code is a statement of the ideals and guidelines for professional and personal behavior of the Medical Staff in all dealings with patients, their friends and families, other health professionals, employees, students, vendors, government agencies, society and among themselves, in order to promote quality of patient care, safety, trust, integrity and honesty.

Each Medical Staff member has a responsibility for the welfare, well-being, and betterment of the patient being served. In addition, the Medical Staff member has responsibility to maintain his/her own professional and personal well-being, and a reputation for truth and honesty.

Guidelines for Interpersonal Relationships

- Treat all medical staff, hospital staff, nursing staff, housestaff, advanced practice providers, students, visitors and patients with courtesy and respect
- You will not engage in the following behaviors:
 - Sexual harassment, making sexual innuendoes or engaging in sexual discrimination
 - Using abusive language or repetitive sarcasm
 - Making threats of violence, retribution, litigation, or financial harm
 - Making racial, religious or ethnic slurs or engaging in racial, religious or ethnic discrimination or making slurs or discriminating on the basis of sexual orientation
 - Using foul language, shouting, or rudeness
 - Criticizing medical staff, hospital staff, nursing staff, advanced practice providers, housestaff, or students in front of others while in the workplace or in front of patients
 - Shaming others for negative outcomes
 - Physically or verbally threatening any one at the Medical Center or on its Campus
 - Engaging in romantic and/or sexual relationships with your current or former patients
 - Revealing confidential patient or staff information to anyone not authorized to receive it

You should:

- Support and follow hospital policies and procedures; address dissatisfaction with policies through appropriate channels
- Use conflict management skills and direct verbal communication in managing disagreements with associates and staff
- Cooperate and communicate with other providers displaying regard for their dignity
- Be truthful at all times
- Wear attire that reflects your professional role and respects your patients
- Develop and institute a plan to manage your stress and promote your personal well being
- Disclose potential conflicts of interests and resolve the conflict in the best interest of the patient

Guidelines for Clinical Practice

- Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation and service
- Respond to patient and staff requests promptly and appropriately
- Respect patient confidentiality and privacy at all times; follow all regulations for release of information
- Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, etc.)
- Seek and obtain appropriate consultation
- Arrange for appropriate coverage when not available
- Provide care in accordance with recognized standards, policies and Code of Conduct
- Do not treat patients while impaired by alcohol, drugs, or illness
- Prepare and maintain medical records within established time frames
- Disclose potential conflicts of interests and resolve the conflict in the best interest of the patient

- When terminating or transferring care of a patient to another physician, provide prompt, pertinent and appropriate medical documentation to assure continuation of care

Guidelines for Relationships with Medical Center & Community

- Abide by all rules, regulations, policies and bylaws of Rush University Medical Center
- Serve on Medical Center, Medical College and medical staff committees
- Assist in the identification of colleagues who may be professionally impaired or disruptive
- Maintain professional skills and knowledge and participate in continuing education
- Refrain from fraudulent scientific practices
- Accurately present data derived from research
- Request appropriate approval from the Institutional Review Board (IRB) prior to human research activities and abide by all laws and regulations applying to these activities
- Cooperate with legal professionals, including Medical Center legal counsel, risk management and compliance unless such cooperation is prohibited by law
- Participate in clinical outcome reviews, quality assurance procedures and quality improvement programs
- Hold in confidence all information pertaining to peer review, quality assurance, and quality improvement
- Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential information.

Compiled from:
Compiled from RUMC Disruptive Physician Policy
AMA Code of Ethics
Stanford Children's Hospital Code of Ethics
RUMC Compliance Policies

II. GENERAL CONDUCT OF CARE

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the hospital only by a member of the medical staff who has appropriate admitting privileges. All practitioners shall be governed by the official admitting policy of the hospital.
2. A member of the medical staff with appropriate clinical privileges shall be responsible for the medical care and treatment of each patient in the hospital whom he admits, and he shall be considered the attending physician for any such patient and shall be responsible for calling specialists as necessary for consultation and, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for timely and appropriate discharge of the patient. Any consultant seeing a patient upon request of the attending physician shall be responsible for transmitting reports of the condition of the patient to the referring practitioner. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
3. Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded within the first 24 hours after admission.
4. Upon request Members admitting emergency cases shall be prepared to justify to the executive committee of the medical staff and the administration of the Medical Center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's chart within 24 hours after admission
5. Patients who are seen in the emergency department and do not have a private practitioner will be assigned an on-call physician from the medical staff who can most appropriately manage the patient's health problem, in accordance with rotating assignments made by the chairperson from the appropriate department, or his/her designee. The emergency department shall have a schedule for such assignments. All physicians so assigned shall provide or make arrangements for continuous care, after discharge if necessary, unless the physician-patient relationship is terminated in accordance with legal and ethical requirements
6. Each practitioner must assume timely, adequate, professional care for his/her patients in the Medical Center by being available or having available through his/her office an eligible covering practitioner with whom prior

arrangements have been made and who has appropriate similar, but not necessarily identical clinical privileges at the hospital.

7. When possible each member of the staff shall name a member of the medical staff who may be called to attend his/her patients when he is on vacation or in an emergency. If he does not, the covering physician shall be as referenced in the Plan of Day for the particular day at issue. If the covering physician does not respond, the chairperson of the department concerned shall have the authority to call any member of the medical staff to provide appropriate coverage resulting in his inability to respond. In the event the chairperson of the department concerned cannot be reached, the president of the medical staff shall have the authority to call any member of the medical staff. In the event the president cannot be reached, the practitioner on call for the specialty involved shall assume responsibility for the case.
8. The Chairperson of each Department 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 approved by the Executive Committee.
9. All admissions shall be coordinated by the Admitting Office in accordance with the policies of the Department Chairperson as noted above.
10. Except in cases of an emergency, patients shall generally be admitted not later than 4:30 p.m.
11. Policies governing restricted bed utilization and patient transfer shall generally be determined by the Department Chairperson or his designee(s). However, no patient will be transferred between units without such transfer being approved by the responsible medical staff member, except in emergencies or when patients require isolation. In these situations, the attending physician and identified consultants shall be notified.
12. Internal Transfer priorities usually shall be as follows:
 - (a) From Emergency Room to appropriate patient bed.
 - (b) From Intensive Care Unit to general care area.
 - (c) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.
13. No patient will be transferred (internally) without such being approved by an attending physician of the medical staff who is responsible for the patient's care.

14. Internal transfer of patients will not be official until written orders are placed in the medical record by the accepting team. The service from which the patient is being transferred will continue to care for that patient until such occurs and until a bed can be found on the service to which the patient is being transferred.
15. If any question as to the need for admission to or discharge from an intensive care unit should arise, that decision is to be made through consultation with the appropriately designated physician(s).
16. The medical staff attending should see that the medical record should contain a reason for hospitalization that shall include certification that any inpatient services are reasonable and necessary and in cases that are not specified as inpatient-only that they comply with the 2-Midnight benchmark, the reason for inpatient services, the estimated time the patient may require in the hospital, anticipated plans for post hospital care and a daily note documenting (a) plan of care, (b) reason for continued need for hospitalization, and (c) approximate time necessary for continued hospitalization. A member of the medical or house staff shall countersign documentation by medical students within twenty-four (24) hours of its entry. The Executive Committee of the Medical Staff will require compliance with these standards as part of the assessment for continued medical staff privileges (Refer to Medical Staff Medical Center Resource Utilization Improvement Project Policy).
17. In addition to the attending physician, the Infection Control Department has the authority to restrict access to patients with potential or known highly contagious diseases.
18. For the protection of patients, the medical and nursing staffs, and the hospital, certain principles are to be met in the care of potentially suicidal patients.
 - (a) Any patients known or suspected to be suicidal in intent shall be admitted under care as outlined in policies and standing protocols adopted with input from the Medical Executive Committee and disciplinary leaves and approved by the Medical Center.
 - (b) The attending practitioner shall be responsible for determining the admission of such patients to another institution when suitable facilities are not available.
19. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

20. Admission to special care units. If any question as to the validity of admission to or discharge from a special care unit should arise, that decision is to be made through consultation with the appropriate unit director concerned.
21. The attending physician is required to document the need for continued hospitalization.
22. Patients shall be discharged in a timely fashion, and only on order of the attending physician.
23. Should a patient leave the hospital against the advice of the attending practitioner or without proper discharge, he/she shall be asked to sign a form titled "Release Against Medical Advice." If the patient refuses to sign the form and leaves, a notation of the incident shall be made in the patient's medical record by a hospital representative, and, in both instances, the attending physician shall be notified.
24. In the event of a death, as defined by local law the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable amount of time. Exceptions shall be made in those instances of terminal disease wherein the patient's course has been adequately documented to within a few hours of death. The body shall not be released until the death certificate has been signed by the appropriate physician and a copy made available for the permanent medical record. Policies with respect to release of deceased bodies shall conform to local law.
25. Tissues or cadaveric organs removed for transplantation may be obtained only after written consent of the patient or family and according to applicable state and federal law. The Medical Center has a policy/protocol pertaining to organ procurement and a written agreement with an OPO that incorporates applicable federal and state law requirements. Medical Staff members should be aware of same and assist the Medical Center in notifying the OPO or its designee in a timely manner of individuals whose death is imminent or who have died in the Medical Center.
26. Every member of the Medical Staff is expected to be actively involved in securing autopsies, or referring cases to the Medical Examiner as outlined below. No autopsy shall be performed without proper written consent. All autopsies shall be performed by the Department of Pathology in accordance with the policies established by that Department. It is the position of the Medical Staff that for all deaths every effort should be made to obtain an autopsy for clinical correlation and research purposes. However, autopsies should be obtained, if at all possible in the following circumstances:
 - (a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

- (b) All deaths in which the cause of death is not known with certainty on clinical grounds.
- (c) Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
- (d) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and 1 or therapies.
- (e) Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
- (f) Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction (refer to M.E.).
- (g) Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (1) persons dead on arrival at hospitals, two (2) deaths occurring in hospitals within twenty-four (24) hours of admission, and three (3) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- (h) Deaths resulting from high-risk infectious and contagious diseases.
- (i) All obstetric deaths.
- (j) All neonatal and pediatric deaths.
- (k) Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplanted organs.
- (l) Deaths known or suspected to have resulted from environmental or occupational hazards.

27. A physician should not be the admitting/attending physician and/or surgeon in treating a member of his/her immediate family. Immediate family is defined as a spouse, children, siblings, and parent of either spouse.

B. CONSENTS

1. Purpose of Consent

Informed consent is obtained to assist the patient in understanding the care and treatment that may be provided and in order to protect the physician, the APP, the nurse, and the hospital against claims of unauthorized treatment. Any treatment or procedure which poses a risk to the patient

should be authorized in writing after the risks and complications have been explained to the patient. A consent given by a patient after such an explanation is commonly referred to as an “informed consent”.

2. **Informing the Patient**

The physician is responsible for fully informing the patient or the consenting party. Under limited circumstances, an RN, APP or other licensed healthcare professional who are performing a procedure themselves can also obtain consent. This may be done orally or in the form of an information sheet.

3. **How The Informed Consent Is Documented In The Medical Record**

A complete informed consent process includes a discussion of the following elements:

- The nature of the proposed care, treatment, services, medications, interventions, or procedures
- Potential benefits, risks, or side effects, including potential problems related to recuperation
- The likelihood of achieving care, treatment, and service goals
- Reasonable alternatives to the proposed care, treatment, and service
- When warranted, the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
- When warranted, any limitations on the confidentiality of information learned from or about the patient

The informed consent is to include that the patient is informed as to who will actually perform surgical interventions that are planned. When practitioners other than the primary surgeon will perform important parts of the surgical procedures, even under the primary surgeon’s supervision, the patient must be informed of who these other practitioners are, as well as, what important tasks each will carry out. The General Informed Consent, Form # 1927, under Informed Consent Affirmation, the physician or authorized licensed person performing the procedure signs the affirmation.

4. **A Consent Must Be Witnessed**

A consent must be witnessed by at least one person who is present at the time the patient signs the consent form. Witnessing a consent form does not mean that the witness is confirming that the patient has been informed

of the treatment, risks and complications or alternative procedures, but simply that the person who has signed the form is that person and has signed the form voluntarily.

5. **Written Consent Form**

Two pre-printed consent forms are available to document the information given to a patient and the voluntary consent given by the patient: General Informed Consent, Form #1927, and General Informed Consent, Short Form #1925.

The General Informed Consent, Form #1927, should be used if the procedure/treatment involves the administration of anesthesia and/or blood products, the examination and disposal of tissue or body parts, and/or photographing or televising of the procedure/treatment.

The General Informed Consent, Short Form # 1925 may be used if the proposed procedure/treatment does not involve anesthesia, removal of tissue or body parts, or photographing/televising of the procedure/treatment.

C. PATIENT CARE PROVISIONS

1. The admitting physician, or physicians, shall be responsible for the medical care and treatment of each patient in the Medical Center, for requesting consultations when indicated, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
2. All orders for treatment shall be entered electronically and accurately authenticated with full signature and title, date and time by a member of the adjunct, active medical staff or house staff, by a Physician Assistant who has privileges at the Medical Center to do so by an Advanced Practice Nurse (APN) who has privileges at the Medical Center to do so and is also licensed as an advanced practice registered professional nurse in accordance with the State of Illinois Nursing and Advanced Practice Nursing Act. Verbal orders are governed by the provisions of the medical records sections of these rules.
3. All previous orders are cancelled when patients undergo operative procedures.
4. The attending physician or his/her designee shall clearly explain the outcome of any treatments or procedures to the patient and, when appropriate the family, whenever those outcomes differ significantly from the anticipated outcomes.

5. The Rush University Medical Center Formulary includes those drugs, which have been approved by the Pharmacy and Therapeutics Committee to be routinely stocked in the hospital's pharmacy. Drugs not included in the formulary may be ordered on a patient-specific basis.
6. Unless renewed, all narcotics orders will be discontinued after seventy-two (72) hours and the physician or APP will be notified.
7. All Staff and Faculty members conducting research utilizing Medical Center resources must follow the Policy Regarding Review of Research Proposals and Activities as described in the Medical Staff Policy Manual section of these Rules & Regulations.
8. It is the duty of the Medical Center Staff through its Department Chairperson and the Executive Committee to insure that members of the Staff do not fail in the matter of calling consultations as needed.
9. Except in an emergency, consultation with another qualified physician, or physicians, is required in cases in which according to the judgment of the physician:
 - (a) The patient is not a good risk for operation or treatment;
 - (b) The diagnosis is obscure;
 - (c) There is doubt as to the best therapeutic measure to be utilized; and
 - (d) In unusually complicated situations where specific skills are necessary.
10. When others caring for the patient believes there is need for a consultation, this should be brought to the attention of the Department Chairperson who may arrange for a consultant or decide one is not necessary. In either case, the action should be recorded with the Vice President for Medical Affairs.
11. A satisfactory consultation includes examination of the patient and the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.
12. A consultant must be well qualified to give an opinion and/or recommendation in the field in which his/her opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of an individual's training, experience and competence.
13. Each Department, Section or Division, will provide at least one attending physician who will be available/accessible twenty-four (24) hours daily to

accept calls and facilitate patient care. In doing so, it is the Chairperson or designee's responsibility to generate a monthly schedule of attending(s) that will be available for such duties. Necessary schedule information must include: attending's name, pager number, and/or a telephone where the physician can be reached for the entire 24-hour period.

14. It is the responsibility of each department to submit this information to the Director of Telecommunications Department and the Plan-of-the-Day coordinator at least 2 weeks prior to the start of the month.
15. Policies concerning operations performed for the sole purpose of sterilization on either male or female patients shall be governed by written departmental regulations.

D. SUPERVISION OF RESIDENTS

House Staff physicians shall be under the supervision of an Attending Physician. It is the responsibility of each program to arrange for supervision of House Staff in all of their clinical activities. Areas of clinical activities that should be supervised include the management of emergency patients, consultations, inpatients, outpatients, performance of procedures, and telephone contacts. Supervision may be in the form of direct observation of the resident/patient interaction, re-examination by the attending, timely discussion of findings and plans between the resident and attending, or other appropriate methods. House Staff should be able to assume increasing responsibility according to their level of education, ability, and experience. Policies regarding supervision of residents should be consistent with the program requirements for each Resident Review Committee. Programs must keep the policies and procedures concerning supervision of residents on file and communicate these to all residents and attendings. When formulated or changed, a copy should be sent to the Dean's designate for purposes of institutional oversight. A listing of the clinical privileges & supervision guidelines for each respective level of post graduate training for all House Staff (interns, residents, and fellows) shall be maintained by the Residency Program Director's Office and available or accessible in the Office of Graduate Medical Education and in patient care areas through the Rush Intranet: Website address: <http://iris.rush.edu/frontpage/clinindex.html>

E. EMERGENCY SERVICES

1. The emergency department shall be operated in a manner consistent with its capabilities, and designation within the Emergency Medical Services System. The medical staff and Medical Center shall develop policies and procedures that assure all those presenting to the emergency department, or to the Medical Center generally for emergency services, regardless of ability to pay, will be provided a medical screening examination consistent with the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA"). In the event an emergency condition is

determined to exist, the individual will be stabilized and provided treatment prior to discharge or transfer in compliance with EMTALA.

2. If an individual (whether eligible for Medicare benefits and regardless of ability to pay) comes by him/herself or with another person to the emergency department (or any other location within the Medical Center) and a request is made by the individual or on the individual's behalf for examination or treatment of a medical condition, the individual will be provided a medical screening examination within the Medical Center's capability, which shall include ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists. The medical screening must be performed by an individual with demonstrated capability or training in providing emergency care and identifying an emergency condition. In this context, the medical staff has designated the following individuals as qualified individuals to perform a medical screening examination: a physician; a physician assistant who holds appropriate clinical privileges under the medical staff bylaws while acting under the supervision of a physician, a nurse practitioner with appropriate clinical privileges under the medical staff bylaws while acting under supervision of a physician.
3. For purposes herein, a medical screening examination shall be sufficient to determine with a reasonable degree of clinical confidence whether an emergency medical condition does or does not exist. The medical screening examination must be the same type of examination that would be performed on any individual coming to the hospital's emergency department with the same signs and symptoms, regardless of the individual's ability to pay. For purposes herein, an emergency medical condition is one that manifests itself by symptoms of sufficient severity (including severe pain/ psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.
4. In the event of an emergency which is life threatening and which occurs within the Medical Center, any licensed physician on the medical staff is authorized to initiate emergency medical care on any patient within the Medical Center, while the attending physician is being notified of the emergency situation. This care may continue under the direction of the initiating physician until the patient's attending physician or his/her designee can assume responsibility for the continuation of treatment.

F. SPECIAL CARE UNITS

The operation of recovery rooms, newborn nurseries, surgical intensive treatment units, coronary care units and other intensive care units of all kinds shall be under the control and direction of the appropriate departments.

G. CLINICAL DEPARTMENTS

The organization of Medical Center clinical departments has been specified in the Medical Staff Bylaws.

H. MEDICAL STAFF MEETINGS

Regular meetings of the Medical Staff shall be held as specified in the Bylaws.

I. STAFF POLICIES

The policies recommended by standing or duly formed ad hoc committees, and committees of the Medical Staff and approved by the Executive Committee, shall be binding on the Staff. The Medical Staff Office shall maintain these policies in a Medical Staff Policy Manual, together with the Staff Bylaws and Rules and Regulations.

J. BLOOD-BORNE PATHOGEN AND TB/INFECTION CONTROL (OSHA) TRAINING REQUIREMENTS

1. All medical staff members with clinical privileges are required to receive blood-borne pathogen and TB/infection control training on Medical Center policies and procedures every calendar year. This training requirement shall be met by utilizing the Medical Center's Healthcare Education System (HES). The Medical Staff Office will be responsible for mailing information regarding the Medical Center's Healthcare Education System (HES) & mandatory training courses to all active medical staff members in January of each year. The Medical Staff member will complete the blood borne pathogen & TB/infection control courses within thirty days (30) of receipt of this information. Upon completion of the required courses, the Medical Staff Office will enter such into the Medical Staff Office database.
2. If the medical staff member fails to complete the training course, the Medical Staff Office will mail a reminder to the medical staff member on a quarterly basis. If the course is not completed by December 1st of that year, the Medical Staff Office will send the medical staff member a certified letter to inform him/her that failure to complete the course by December 31st, will result in the medical staff member being presented to the Medical Staff Executive Committee to consider temporary suspension of their admitting/operating privileges or temporary loss of their active status on the medical staff.

3. Certification from other hospitals or organizations training programs regarding blood borne pathogens/TB control will not be accepted as a substitute for the Rush program. The Cook County/Stroger Hospital Training Program is an exception to this rule. Reciprocity for certification and training will be accepted between the Cook County /Stroger Hospital and Rush Training Programs regarding Blood-borne Pathogens & TB/Infection Control.

K. DISRUPTIVE CONDUCT POLICY FOR MEDICAL STAFF MEMBERS

PURPOSE

- A disruptive physician or APP is an individual who engages in behavior that undermines the culture of safety.
- This policy establishes procedures for evaluation of Medical Staff members and APPs whose conduct may create:
- An environment that is potentially disruptive to the quality or efficiency of patient care, and/or
- An unacceptably negative environment for patients, other Medical Staff Members and/or Rush employees, agents or staff.

POLICY

Unacceptable conduct that may create an environment that is potentially disruptive to the quality and/or efficiency of patient care may include, but is not limited to, the following:

- Attacks or criticisms leveled at Members of the Medical Staff or Medical Center employees, agents or staff that are irrelevant to the workplace or go beyond the bounds of fair professional comment. These behaviors include comments or actions to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence, or other verbal abuse of personnel, including cursing or swearing at another person. Consideration will be given as to whether the inappropriate attack or criticism had a direct impact on patient care or was directed at or observed by an inappropriate third party, such as a patient or patient family member.
- Inappropriate comments written in patient medical records, or other official documents, impugning the quality of care in the Medical Center, or attacking particular Medical Staff Members, Medical Center employees, agents or Medical Center policy.

- Imposing unreasonable requirements on Medical Center employees, agents or staff that do not involve appropriate patient care or Medical Center duties, but serve only to burden them.
- Abusive conduct, demeanor, or comments to patients or families/friends of patients.
- Failure to adhere to the Medical Center compliance plan or federal and/or state laws relevant to the provision of patient care or general conduct at the Medical Center.
- Conduct that leads a person to reasonably believe that his or her safety or security may be in jeopardy.
- Failure on a consistent basis to comply with and adhere to the Medical Staff Bylaws, Rules and Regulations, Code of Conduct, or Medical Staff and Medical Center policies and procedures.

PROCEDURE

1. Employee or staff complaints against Medical Staff Members may be handled by the Medical Staff Physician Conduct Panel which will be appointed by the President of the Medical Staff or his designee. (Note: Patient Complaints about Medical Staff will be handled in accordance with the Rush Operations Policies and Procedures – see policy OP-1048 “Processing of Patient Complaints” and policy OP-0272 “Patient Rights.”) In some instances the complaint may be referred directly for corrective action under the Medical Staff Bylaws.
2. Any Medical Staff member, employee, or staff member may lodge a complaint concerning a Medical Staff member’s conduct.
3. The complaint should be initiated as soon as possible after the incident and no later than thirty days of the incident. However, it is recognized some complaints may be generated by cumulative conduct, warranting an exemption to this time frame.
4. Complaints may be submitted to:
 - (a) Medical Staff Office
 - (b) Department Chairperson
 - (c) Office of the Chief Medical Officer
 - (d) Chairperson of the Medical Staff Physician Conduct Panel
 - (e) Human Resources

- (f) Vice President, Nursing Services
- (g) General Counsel's Office

These above individuals will ensure that the complaint will be forwarded to the panel.

5. The panel Chairperson will convene the panel to hear the complaint within 2 weeks of the completion of the investigation of the complaint.
6. Panel members will include seven voting members and three ex officio members. Voting members consist of two permanent members, the Chairperson, who will be the President-elect of the Medical Staff, and the Chief Operating Officer of RUMC. The other five voting members will be:
 - Chief Medical Officer
 - Chairperson or the Chairperson's designee of the physician who is the subject of the complaint
 - Chairperson/Executive from the complainant's area
 - Two members of the Medical Staff Executive Committee appointed by the President
 - Representatives from Human Resources, Risk Management and Legal Affairs will serve as ex officio members of the panel.
7. The panel will act in coordination with the Medical Staff Professional Assistance Committee, the Medical Staff Office, the Department of Legal Affairs and all other relevant Medical Center bodies.
8. Either Human Resources, Department of Employee Relations or the General Counsel's Office, will serve under the direction of the Chairperson, as staff to the panel. They will conduct the investigation, maintain investigative documents and records of decisions.
9. Panel deliberations will be confidential. Results from the panel may include, but not be limited to:
 - Recommendations for referral to the corrective action process of the Medical Staff Bylaws,
 - Documentation in a Medical Staff member's file,
 - Referral to the department chairperson for action,
 - Referral to the Medical Executive Committee for action, and/or

- Referral to Medical Staff Professional Assistance Committee

OTHER RELEVANT POLICIES

- Medical Staff Bylaws
- Physician Health Policy
- RUMC Human Resources Policies and Procedures
- RUMC Operating Policies and Procedures

III. HEALTH INFORMATION MANAGEMENT/MEDICAL RECORD RULES

Medical Records Rules

1. All medical records must be documented and maintained in accord with the Hospital's policies on Medical Record documentation and completion as may be amended from time to time.
2. The attending physician, unless he/she transfers the patient to another physician's service, is responsible for the preparation of a complete and legible medical record for each patient.
3. Each patient's medical record shall be accurate, timely and legible. This record shall include identification data; admission information; complaint; history of present illness; relevant medical/surgical history; family history; physical examination; special reports, such as consultations, clinical laboratory, radiology and other services, provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis or diagnostic impression; condition on discharge; discharge note or summary; and autopsy report when performed.

For all patients undergoing surgical/invasive procedures, the following must be recorded prior to the performance of the procedure: 1) a history and physical examination; 2) the results of any indicated diagnostic tests; and 3) a provisional diagnosis. The determination of the appropriateness of the procedures shall be based on the information obtained from this assessment. For emergent procedures, the physician may defer or limit the information or data obtained if the patient cannot communicate or if the nature of the situation requires immediate intervention.

Medical History and Physical Assessment Completion

- a. The history and physical assessment is completed within twenty-four (24) hours after the admission, and shall be authenticated by a member of the

medical staff or house staff. If using an H&P that is thirty (30) days old or less, an updated note must be placed in the medical record within the same time frame as above.

- b. The medical staff attending is responsible for assuring that the history and physical examination is timely completed, authenticated and present in the medical record.
- c. The history should be obtained from the patient whenever possible and should include, but not be limited to: the chief complaint; details/history of present illness; current medications); allergies; past medical history; past surgical history; social history; family history; and review of systems.
- d. The physical examination shall include at a minimum, a cardiac and pulmonary exam and the physical area(s) that address the reason for admission (chief complaint).
- e. Obstetrical records shall include all prenatal information.

Medical History and Physical Assessment Completion by Practitioners Other Than RUMC Physicians (Applies to Inpatients and Non-Inpatients)

- a. An Advanced Practice Nurse (APN) or a Physician Assistant (PA) collectively known as Advanced Practice Providers (APP) may perform the history and physical examination if they have been privileged to do so by the medical staff.
- b. History and physical examinations completed by medical students, APN and/or PA students are for educational purposes only and do not meet the required H&P standards, even if authenticated by a RUMC medical staff or house staff physician or APP.
- c. If a H&P is completed by a physician who is not a member of the RUMC medical staff or house staff, an updated assessment must be performed by a medical staff or house staff physician (or APN or PA per above). The assessment shall confirm and update any information and findings (including, but not limited to the physical examination, chief complaint, details/history of present illness; current medications; allergies; past medical history; past surgical history; social history; family history and review of systems, as necessary, and shall be documented and authenticated in the medical record by the physician (or APN or PA) Obstetrical patients shall have prenatal information assessed and pediatric patients shall have developmental age factors and educational needs assessed as appropriate.

Record of Care Components

- 1.. For non-invasive tests/procedures: if it is necessary for an anesthesiologist to administer sedation or anesthesia for an ambulatory, non-invasive radiological test/procedure (e.g. CT scan, MRI, etc.), then the completed pre-anesthesia assessment fulfills the requirement for the history and physical exam and the problem focused H&P is not required in this particular situation only.
2. History and Physical Completion Upon Readmission.
 - (a) If a patient is readmitted within thirty-days (30) of discharge for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be substituted for the medical history and physical assessment.
 - (b) The medical record shall contain a current, physical examination prior to any operative and/or invasive procedures. The medical history and physician examination must be completed and documented in hospital records by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual with appropriate privileges to do so in accordance with state law and hospital policy.

Suspension for Delinquency.

1. A practitioner's scheduling and admitting privileges will be automatically suspended:
 - (a) in the event one or more incomplete patient medical records of the practitioner are available and have not been completed within thirty (30) consecutive days after the discharge of the patient;
 - (b) in the event one or more patient medical records of the practitioner lack a history and physical examination or operative report at the time of discharge, upon issuance of the subsequent suspension list by the Director of Health Information Management; or
 - (c) in the event of failure to pay dues.

The suspension process shall be conducted in accordance with the process set forth herein and in the Medical Staff Bylaws. Suspension shall remain in effect until the practitioner has cured the reason for suspension pursuant to Medical Staff Bylaws.

The suspended practitioner's designated alternate shall assume responsibility for the patient. If he is unavailable, then the Chairperson of the suspended practitioner's Department shall appoint a member of the Medical Staff to assume management of the patient.

2. The attending physician, dentist, or podiatrist is responsible for the daily observation and evaluation of each in-patient, either personally or by another physician who is a member of the medical staff. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability and, except as may be provided in medical staff policies, shall be countersigned by the appropriate attending physician. Failure to comply with these requirements may result in initiation of corrective action.
3. A progress note shall be written in the medical record immediately after each inpatient and outpatient procedure. When a comprehensive operative report cannot be entered immediately into the patient's medical record after the operation or procedure, a brief operative note shall be written in the medical record before the patient is transitioned to the next level of care. A comprehensive operative report shall be dictated or written within 24 hours after each inpatient and outpatient procedure. Brief operative notes shall include: the name of the practitioner performing the procedure and assistants, if any, findings(s), procedures(s) performed and description of the procedure(s), estimated blood loss, as indicated, specimens removed, and postoperative diagnosis. The completed comprehensive operative report shall be authenticated by the practitioner performing the procedure and made available in the medical record as soon as possible after dictation.
4. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report shall be authenticated and made a part of the patient's record. A limited statement, such as "I concur," does not constitute an acceptable report of consultation. When procedures are involved, the consultation note shall be reported prior to the procedure except in emergency situations so verified on the record.
5. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
6. Each clinical entry in the patient's medical record shall be accurately dated and authenticated by a member of the medical staff, an Advanced Practice Provider, or one of the following individuals who is either employed by or under specific contract with the hospital to provide patient care: registered professional nurse, licensed practical nurse, student nurse (under supervision), registered or certified respiratory therapist, licensed physical therapist, licensed physical therapist assistant, registered and licensed occupational therapist, certified occupational therapist assistant, certified speech and language pathologist, certified audiologist, certified prosthetist, certified orthotist, certified athletic trainer, registered dietician, registered

pharmacist, clergy, social worker or infection control staff. Such individuals may electronically document and authenticate their own medical record entries upon meeting the following requirements:

- (a) The individual is assigned a unique password that is generated through a confidential access code.
- (b) The individual acknowledges and agrees in writing that his/her unique password will be kept strictly confidential and that the hospital will terminate the use of the password in the event that it has been misused. "Misused" shall mean that the user has allowed another person or persons to use his/her password, or that the password has otherwise been inappropriately used.
- (c) The individual certifies in writing that he/she is the only person with user access to the password and the only person authorized to use the signature code.
- (d) The individual acknowledges and agrees in writing that the hospital will monitor the use of passwords periodically and take corrective action as needed.
- (e) The individual authenticates each report and entry separately and only after verification of the accuracy of its content.
- (f) Physician authentication of medical record entries by use of a signature stamp may be permitted upon meeting the following requirements:
 - (1) The physician certifies in writing that he/she is the only person with access to the stamp.
 - (2) The physician certifies in writing that he/she is the only person who uses the stamp.
 - (3) The certification statement is maintained in Medical Records.

- 7. All transcribed documents requiring a signature and available electronically shall be signed electronically.
- 8. Practitioners shall not disclose any codes that allow access to confidential information. Practitioners shall be responsible for all activities undertaken using their access codes, including misuse or wrongful disclosure of confidential information. Practitioners shall not disclose their access code or use the access codes of others.

9. Abbreviations and symbols may be used only when they have been approved by the medical staff. An official record of approved abbreviations and symbols as well as mandated "do not use" abbreviations and symbols shall be referred to in Medical Records policies as may be amended from time to time and same shall be available on the nursing units and in treatment areas.
10. A discharge summary as described by the Joint Commission (which is available from Medical Records) shall be recorded on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries and normal newborn infants. A discharge summary shall be recorded on all inpatient deaths regardless of length of stay.

All discharge summaries shall be authenticated by the responsible practitioner. A final progress note shall be sufficient for the exceptions specified above provided that the final diagnosis, patient condition on discharge, discharge instructions, and follow up care are recorded in the medical record.
11. All medical records are the property of the hospital. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with federal or state law, court order or subpoena. Electronic records shall not be reproduced in or out of the hospital for any reason other than medical care of a patient, and then that information must be securely safeguarded from unauthorized access. Release of any information pertaining to medical records shall be done in accordance with all applicable federal and state laws governing such release of information.
12. In case of readmission of a patient, all previous medical records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.
13. The radiology department is to provide a record for inpatient charts in which the patient is receiving radiation therapy. Each treatment shall be recorded on the chart at the time of treatment and left with the chart as a permanent part of the record. At the end of the period of treatment, a brief summary stating that this point has been reached and the total amount of radiation received is to be recorded.

GENERAL CONDUCT OF CAREA general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer shall notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. Specific consent forms approved by the medical staff for surgical or other procedures with inherent patient risks, shall be signed as well.

2. The completed medical record shall include a summation of the hospitalization including, but not limited to: the reason for hospitalization; significant findings; procedures performed; treatment rendered patient's condition at discharge; and any specific instructions given to the patient and/or family. Medical staff members and Advanced Practice Professionals shall utilize the clinical information systems provided by the Medical Center for the medical and surgical care of hospital patients.
3. No medication, treatment, or diagnostic test shall be administered to a patient except on the written order of a member of the medical staff, resident, fellow, or advanced practice provider holding appropriate clinical privileges in accordance with medical staff policies. Verbal orders shall be used in emergencies only and shall be signed and dated by the practitioner giving the order prior to leaving the area. Telephone orders shall be used only when practically necessary and shall be signed and dated by the practitioner giving the order within 72 hours.

A telephone order (as that term is defined by the Joint Commission) shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence and signed by the responsible practitioner within 72 hours. A duly authorized person is defined as a physician assistant, advanced practice nurse, registered professional nurse, registered or certified respiratory therapist, licensed physical therapist, registered and licensed occupational therapist, certified speech and language pathologist, certified audiologist, certified prosthetist, certified orthotist, certified clinical scientist/medical technologist, registered dietician and registered pharmacist. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated, with the name of the practitioner giving the order. On all telephone orders, the responsible practitioner must allow time for the above designated person to repeat the order to him/her so that there is no chance for error. Signed facsimile orders are viewed as written orders and may be accepted in accordance with hospital policy.

Automatic substitutions based on hospital formulary approved by the Pharmacy and Therapeutics Committee and Medical Executive Committee need not be countersigned.

4. The practitioner's order must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
5. All current orders are canceled when patients go to surgery, with the exception of a Do Not Resuscitate (“DNR”) order, which shall be handled in accordance with the medical staff policy on Do No Resuscitate orders. No blanket “resume” orders are allowed. Therefore, all orders must be re-written after surgery.
6. All drugs and medications administered to patients shall be listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service of AMA Drug Evaluations, or be in common usage in the community. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the regulations of the Food and Drug Administration.

Medical, surgical, and clinical research involving the use of investigational drugs and devices shall necessitate the approval of an Institutional Review Board Committee. An appropriate consent form approved by this committee shall be signed by those involved in such projects.

7. All practitioners shall comply with the Medical Center/Medical Staff policies relating to conduct, maintenance of privileges and as otherwise applicable to these, as may be adopted and amended from time to time. In the event a practitioner’s application for re-appointment is received by the MSO in an untimely manner, the MSO will refer the application to the applicable Department Chairperson to determine whether the application is acceptable for processing.
 - (a) Attending physicians with assigned, delinquent discharge summaries and/or operative reports that are not authenticated, shall receive a letter of notification of the number of delinquent records every week for two consecutive weeks (14 days) for which there are delinquent records. For the second week (on day 14), the Medical Records Department will contact the physician by telephone to inform him/her that they will receive temporary suspension of staff privileges in the hospital, (including but not limited to: admitting, clinical and operating privileges) for any records that remain delinquent. This temporary suspension will occur on day fourteen (14). In addition, the Health Information Management Department will send a certified letter to the physician informing him/her of the suspension.
 - (b) Attending physicians who still fail to complete all available medical records by the third consecutive week after having received such notification for two consecutive weeks, will receive automatic

temporary suspension of staff privileges in the hospital, (including but not limited to: admitting, clinical and operating privileges).

- (c) If temporary suspension occurs, the suspension will remain until all available medical records have been completed (suspension will be removed as soon as all records are completed. Attending physicians who still fail to respond one week beyond the date of suspension (21 days), will receive an automatic continuation of suspension of medical staff privileges in the hospital, (including but not limited to: admitting, clinical and operating privileges), for an additional thirty days from the time of completion of the records. This suspension can only be waived with the specific approval of the President of the Medical Staff. Physicians will be directly contacted by telephone, by the Health Information Department, on the day of the initial suspension to inform them of the thirty-day (30) suspension rules as noted above. Attending physicians, who fail to respond even after a thirty-day suspension, will be subject to termination from the Medical Staff.
- (d) Any medical staff attending physician who is suspended due to delinquent medical records four (4) times in any twelve (12) consecutive months will be fined one thousand (\$1,000). Once a physician is suspended and fined, the suspension will not be removed until 1): all outstanding records are dictated and/or signed, AND 2) the \$1,000 fine is paid in full.
- (e) All operative cases done in the Operating Room (OR) and/or Labor & Delivery (L&D) will be assigned by the OR charge nurse to the attending physician or their appropriate designee. An “appropriate designee” for this purpose shall be defined as resident, fellow or advanced practice provider. The assigned attending physician (or designee) is required to complete the brief operative note, when necessary, and the comprehensive operative report. If the assigned designee does not fulfill the requirements, the case is automatically assigned back to the attending physician. For incomplete medical records, as defined above in sections a, b, c, & d of these rules and regulations, the attending physician will be notified and his/her clinical privileges will be subject to suspension in the usual and customary manner.

A. MEDICAL RECORD DOCUMENTATION FOR PSYCHIATRIC SERVICES – RESTRAINTS

Reference the Psychiatry Services Policy Manual.

B. MEDICAL RECORD DOCUMENTATION FOR PSYCHIATRIC SERVICE –SECLUSION

Reference the Psychiatry Services Policy Manual.

C. MEDICAL RECORD – ELECTRO-CONVULSIVE THERAPY (E.C.T.)

Reference the Psychiatry Services Policy Manual.

D. CONFIDENTIALITY OF RECORDS

1. **Confidentiality**: As a condition of membership all staff members must maintain and safeguard the confidentiality of all patient, personnel, student and financial data and records, whether kept in paper or electronic form (hereafter referred to as “confidential information” or “confidential record(s)”). These records include but are not limited to any and all patient protected health information under the Health Insurance Portability and Accountability Act (HIPAA) and any and all student information under the Family Educational Rights and Privacy Act (FERPA).

2. **Disciplinary Procedure** For any violation of accessing and/or disclosing confidential information or records, the involved person(s) will be subject to disciplinary action based on the level of the violation. Violations of confidentiality have been divided into the following two categories with the corresponding disciplinary action for each category of violation.

(a) **Category 1: Inadvertent Access and/or Disclosure** – This level of violation occurs when a person unintentionally or carelessly accesses or reveals confidential information to others without a legitimate need-to-know. Examples include, but are not limited to:

- Leaving inadvertently a copy of a confidential record in the cafeteria or library;
- Leaving a computer unattended in an accessible area with a confidential record unsecured.

Exception: A Category 1 violation of inadvertent access does not include accessing a confidential record by mistake for a brief duration without any reasonable justification (e.g., requesting of a medical record of a similarly named patient and looking up an incorrect name in the electronic record).

Disciplinary action may be administered in the following order:

First Offense: Counseling

Second Offense: Issuance of a Written Warning

Third Offense: Issuance of a Final Warning with or without a Suspension from the Medical Staff

Fourth Offense: Revocation of staff membership

Disciplinary action for this offense is typically administered in a progressive fashion starting with the least severe, but may be issued at any point in the sequence above based on the individual circumstances involved. b) Category 2: Intentional and Unauthorized Access and/or

(b) **Category 2: Intentional and Unauthorized Access and/or Disclosure** – This level of violation occurs when a person intentionally accesses and/or discloses confidential information for purposes other than the care of the patient or outside the scope of a job role, or for other unauthorized purposes. Examples include, but are not limited to:

- Looking up birth dates;
- Accessing a public personality’s medical record;
- Accessing a relative’s, friend’s, or co-worker/s medical record without proper authorization (for example, without properly completing and submitting an Authorization for Release of Patient Health Information form (MR Form 1928) **which is the preferred method of obtaining authorization,*** or obtaining the verbal consent of the patient);
- Discussing or sharing in any form a patient’s information with another person who is not a health care provider either directly or indirectly involved in the patient’s care;
- Unauthorized delivery of any portion of a patient’s medical record to a third party

Exception: A Category 2 violation does not include the intentional access of a confidential record by the following employees who have the legal right to access the electronic record:

- individuals accessing their own confidential records,
- parent of a minor child if the minor child does not have the legal right to consent as enumerated in OP & P 0029, Section C.4.b.,
- patient’s legal guardian or legal representative as defined by state law (e.g., those who have a power of attorney).

3. **Disciplinary Action**

- (a) Disciplinary action may be administered in the following order for accessing and/or disclosing confidential information of another person without proper authorization:

First Offense: Issuance of a Written Warning

Second Offense: Final Warning with or without a Suspension from the Medical Staff Medical Staff Rules and Regulations

Third Offense: Revocation of staff membership

- (b) Notwithstanding the foregoing, The Rush University Medical Center and/or the Medical Staff reserves the right, in its sole discretion, to revoke staff membership, even for a first time offense/ depending on the circumstances for a Category 2: Intentional and Unauthorized Access and/or Disclosure violation. For example, when a person discloses confidential information without properly completing and submitting MR form 1928 or having the verbal consent of the patient, he or she may lose his or her membership on the medical staff for the first time offense.
- (c) For categories 1 and 2, a medical staff member may also receive a higher level of discipline or have membership from the Medical Staff revoked for a first time offense of a confidentiality violation if he/she has a record of disciplinary action(s) for offenses unrelated to confidentiality violations.

4. **Investigation Procedure for All Categories of Suspected Patient Confidentiality Violations**

The following process should be followed when a violation or suspected violation of patient confidentiality occurs:

- (a) An alleged violation of patient confidentiality shall be reported to the HIPAA Privacy Office at extension 2-2995.
- (b) The HIPAA Privacy Officer will alert the medical staff member's immediate supervisor his or her department chairperson, the Chief Medical Officer and the Director of Medical Staff Operations of instances of unexplained access and/or allegations of violation of patient confidentiality.
- (c) The HIPAA Privacy officer, in collaboration with the Chief Medical Officer and the medical staff member's department chairperson, will review and investigate the alleged violation to determine necessary actions.

5. **Investigation Procedure for All Suspected Confidentiality Violations (Confidentiality Violations of Personnel, Student and Financial Data)**

The following process should be followed when a violation or suspected violation of confidentiality of personnel, student and/or financial data occurs:

- (a) An alleged violation of confidentiality shall be reported to the medical staff member's department chairperson, the Chief Medical Officer, the Director of Medical Staff operations and the General Counsel's Office.
- (b) Upon notification of the alleged violation, the department chairperson in collaboration with Chief Medical Officer and General Counsel will review and investigate the alleged violation to determine necessary actions and/or discipline.
- (c) Nothing contained herein shall be construed to circumvent or allow deviation from the Medical Center's HIPAA Compliance policies and procedures. In the event of an actual or perceived contradiction, the HIPAA compliance policies and procedures shall control.

CONSULTATIONS

1. The good conduct of medical practice includes the proper and timely use of consultation. Judgement regarding the severity of the illness or any question relative to the diagnosis and treatment rests with the practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized medical staff, through its department chairperson and executive committee to see that those with clinical privileges do not fail in the matter of calling consultations as needed. The consultant must be well qualified to give an opinion in the field in which an opinion is sought. Such factual consultation includes examination of the patient and the record, and the written opinion signed by the consultant, which is made part of the record. When operative procedures are involved, a consultation note, except in an emergency, shall be recorded prior to operation. In circumstances of great emergency or where consultation is required by the rules of the hospital, the chief executive officer shall at all times have the right to call in a consultant or consultants after conference with the president of the medical staff.

Members of the staff who are called in consultation, where the attending practitioner does not have necessary privileges for management of care, shall assume responsibility for the management of the patient's care within his area of specialty.

2. Consultation is required in the following conditions:

- (a) In situations where specific skills of other practitioners may be needed;
 - (b) When requested by the patient or patient's legal representative; and
 - (c) For any medical patient who has over-dosed, attempted suicide and/or expressed suicidal ideation (psychiatric consult).
3. The attending practitioner is primarily responsible for requesting consultation when indicated and for designating and calling a qualified consultant. The attending practitioner shall include the reason for the consult request. The attending physician will provide written authorization to permit another practitioner to attend or examine the patient, except in an emergency. Unless otherwise specified by the attending physician, consultant evaluations shall be completed within 24 hours of the request.
 4. If a consultant is unavailable for any reason, he shall immediately notify the attending physician who may then request another consult in a timely manner. The consultant shall provide the basis for his unavailability.
 5. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor who, in turn, may refer the matter to the director of nursing. If warranted, the director of nursing may bring this matter to the attention of the chairperson of the department wherein the practitioner has clinical privileges, or the president of the medical staff if the chairperson cannot be reached. Where circumstances are such as to justify such action, the chairperson of the department may request a consultation.

GENERAL RULES REGARDING SURGICAL CARE All surgical cases must receive adequate preoperative study including a complete preoperative history and physical so that as accurate a diagnostic impression as possible can be established and the operative risk of the patient clearly evaluated. A surgical assistant may perform a preoperative history and physical as long as it is countersigned by the surgeon prior to the surgery. Except in severe emergencies, the history and physical, including preoperative diagnosis, and required diagnostic tests must be recorded on the patient's medical record prior to any surgical procedure. When the history and physical examination and required diagnostic tests are not recorded before an operation or any potentially high risk procedure, the procedure shall be canceled unless the attending practitioner states in writing that such delay would be detrimental to the patient. In a case where the history and physical examination has been dictated but not yet transcribed and appended to the chart, the summary of pertinent findings should be written on the chart together with the information that the history and physical were dictated. In any emergency, the practitioner shall make a note regarding the patient's condition prior to induction of anesthesia and start of surgery. Where imaging studies are indicated, they must be done

in an acceptable radiology laboratory, and, if done outside the hospital, the appropriate reports must be appended to the patient's clinical record preoperatively.

2. When a patient is admitted for dental care or podiatric care, there is a dual responsibility involving the dentist or podiatrist and practitioner member of the medical staff.

(a) Dentist responsibilities.

- 1) A detailed dental history justifying hospital admission. However, properly credentialed oral and maxillofacial surgeons shall perform a complete history and physical on a patient with no known medical diagnosis.
- 2) A detailed description of the examination of the oral cavity and a preoperative diagnosis.
- 3) A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination.
- 4) Progress notes as are pertinent to the oral condition.
- 5) Discharge summary.

(b) Podiatrist responsibilities.

- 1) A detailed history of the problem justifying admission.
- 2) A detailed description of the examination of the area with a preoperative diagnosis.
- 3) A complete operative report describing the findings and operative technique consistent with Medical Center Policy.
- 4) Progress notes accurately and completely written to reflect the area involved.
- 5) Discharge summary.

(c) Physician responsibilities.

- 1) Medical history pertinent to the patient's general health.
- 2) A physical examination to determine the patient's condition prior to anesthesia and surgery.

- 3) Supervision of the patient's general health status while hospitalized.
- (d) The discharge of the patient shall be on written orders of both the dentist or podiatrist and the physician member of the medical staff.
3. A written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent of surgery cannot be immediately obtained from the parents, guardian, or next of kin, these circumstances shall be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
 4. The anesthesiologist shall maintain a complete anesthesia record to include evidence or preanesthesia evaluation and postanesthesia follow-up of the patient's condition.
 5. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.
 6. Tissues and foreign materials removed at the operation shall be sent to the hospital pathologist when required by law and when otherwise requested by the surgeon. The pathologist shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

EMERGENCY SERVICES The medical staff shall adopt a method of providing medical coverage in the emergency department. This shall be in accord with the hospital's basic plan for delivery of such services, including the delineation of clinical privileges for all practitioners who render emergency care.

2. If any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him/herself or with another person to the emergency department (or any other location within the hospital) and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The medical screening may be performed by any physician who is a member of the hospital's medical staff with appropriate clinical privileges, a physician assistant who holds appropriate clinical privileges as an Advanced Practice Professional under the medical staff bylaws while acting under the supervision of such a physician, nurse practitioner with appropriate clinical privileges while acting under the

supervision of such a physician or a qualified registered nurse acting under the supervision of such a physician.

3. The duties and responsibilities of all personnel serving patients within the emergency department shall be defined in a procedure manual reflecting specifically to this outpatient facility. The contents of such a manual shall be developed by the emergency department. Those portions of the manual pertaining to medical staff members other than members of the emergency department shall be approved by the Medical Executive Committee and shall be kept in the emergency department. Patients who are seen in the emergency department and do not have a private practitioner will be assigned an on-call physician from the active or associate staff who can most appropriately manage the patient's health problem, in accordance with rotating assignments made by the chairperson from the appropriate department or his/her designee. Upon request by the emergency department, the assigned physician or his/her designee is required to respond to the needs of the patient, including provision a medical screening examination when needed, and to provide at least one follow-up visit within seventy-two hours after the patient's release from the emergency department, unless a later follow-up visit is recommended by the emergency department. On-call specialty rosters shall be prepared by the chairperson of the appropriate department(s) or his/her designee(s) as necessary to ensure coverage in the emergency department and other areas of the hospital. Each physician who provides such coverage shall arrive at the hospital in response to calls within such time as may be necessary to comply with rules, regulations or policies of the medical staff, the emergency department or the physician's department.
4. Emergency physicians shall meet all criteria for delivering such services as defined by applicable state and federal laws and regulations.
5. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated into the patient's hospital record, if such exists. The record shall include:
 - (a) Adequate patient identification.
 - (b) Information concerning the time of the patient's arrival, means of arrival, and by whom transported.
 - (c) Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to his/her arrival at the hospital.
 - (d) Description of significant clinical, laboratory and roentgenologic findings.
 - (e) Diagnosis.

- (f) Treatment given.
 - (g) Condition of the patient on discharge or transfer.
 - (h) Final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow-up care.
6. Each patient's medical record shall be authenticated by the practitioner in attendance who is responsible for its clinical accuracy.
 7. There shall be a quarterly review of the department's medical records by the emergency department to evaluate the quality of emergency medical care. Reports shall be submitted to the medical executive committee.

SPECIAL CARE UNITS For special care units, including, but not limited to the post anesthesia care unit, intensive care area, cardiac intensive care unit and neuro/burn intensive care unit, appropriate committees of the medical staff shall adopt specific regulations, which will be adhered to by members of the Medical Staff. With respect to STEMI patients, the department of Cardiology and Emergency Department shall coordinate to ensure that a board certified Interventional Cardiologist is on call 24/7.

IV. MEDICAL STAFF APPOINTMENT AND REAPPOINTMENT RULES

A. GENERAL POLICY & PROCEDURE

1. The Medical Staff Policy & Procedure for Medical Staff Appointments and Reappointments shall be reviewed and approved by the Medical Staff Executive Committee at least every two (2) years.
2. All medical staff members regardless of their administrative duties shall be subject to the same appointment and reappointment policies and procedures as outlined in the Medical Staff Bylaws.
3. An application for Medical Staff membership will be considered complete when it fulfills all of the requirements listed in the Medical Staff and Faculty Appointment Policies & Procedures.
4. The Medical Staff Appointment Application at a minimum shall request the following information:
 - (a) Previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration;
 - (b) Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and

- (c) Adverse judgments rendered or settlements made as a result of professional liability lawsuits.
- (d) Cover letter from Department Chairperson
- (e) Advisory Committee Approval
- (f) Written attestation that the Department Chairperson has Verified Identification of Each New Applicant*
- (g) Rush University Recommendation Form
- (h) Completed Medical Staff Application Form
- (i) Clinical Privilege Form
- (j) Medical School Education
- (k) Residency Training
- (l) Unrestricted Illinois State License**
- (m) Illinois State Controlled Substance License
- (n) Federal DEA License
- (o) Malpractice Coverage (\$1,000,000/\$3,000,000)
- (p) Curriculum Vitae
- (q) Three Reference Letters
- (r) National Practitioner Databank Query
- (s) Verification from the applicant that he is fit and able to perform the privileges requested and a signed release from the applicant as referenced in the Medical Staff Bylaws.
- (t) Academic appointment paper work
- (u) Medicare/Medicaid attestation
- (v) Attestation of Behavioral Code of Conduct
- (w) Release Form

*Use of government issued I.D. (e.g. driver's license or current passport is recommended although other methods may be applicable.

**IL Dept. of Professional Regulations website Express Access License Look-Up is an approved method for proof of having an IL State License & as a primary source for verification.

5. Medical Staff Executive Committee recommendations for Medical Staff Appointment shall not be forwarded to the Board of Trustees for final approval until the Medical Staff Office has received completed information for all items listed above in #3 and primary source verification of state license, National Practitioner's Databank, medical school education and residency training.

B. TEMPORARY PRIVILEGES

See the Medical Staff Bylaws

C. TEMPORARY PRIVILEGES FOR SPECIFIC PATIENTS

1. Physicians requesting temporary privileges for the care of specific patients for a limited number of procedures or a specific time frame (i.e. one day) must fulfill the requirements as listed in the Medical Staff & Faculty Appointment Policies & Procedures. The following items are mandatory requirements for temporary privileges for specific patients:
 - (a) Cover memo from Department Chairperson describing the basis for the need for Temporary Privileges and the specific patient(S)1 treatment(s), and/or the procedure(s) to be performed including the specific time frame for patient care.
 - (b) Current Illinois State License or Valid Visiting Physician Permit
 - (c) Current Malpractice Coverage*
 - (d) Documentation that Malpractice Coverage is without geographical limitations.

* Malpractice coverage limits must meet the requirements as specified in the Medical Staff Bylaws. Waiver of this requirement can only be approved by a quorum of the Medical Staff Executive Committee.
2. Following approval of temporary privileges, the Medical Staff Office shall notify the Operating Room and/or appropriate patient care floor/area of the nature and extent of privileges granted.

D. DISASTER PRIVILEGES

See the Medical Staff Bylaws

E. EMERGENCY PRIVILEGES

See the Medical Staff Bylaws

F. TELEMEDICINE PRIVILEGES

See the Medical Staff Bylaws

G. RULES FOR RESIDENTS PERFORMING NON-SUPERVISED ACTIVITIES (OUTSIDE SCOPE & DUTIES OF RESIDENCY TRAINING PROGRAM) AS INDEPENDENT PRACTITIONERS AT RUMC

The following rules apply to residents and/or fellows who are eligible to perform non-supervised patient care activities within the Medical Center and are members of the Medical Staff, that are outside the scope & duties of the residency training program, for which it is necessary to have clinical privileges for independent practice. Three elements are involved: the resident must satisfy departmental and institutional criteria for such activities; the resident must satisfy all requirements for privileging in the area of practice; there must be a clear delineation between the training experience and the independent practice experience.

A written protocol must exist in the employing department that will contain the following elements:

- (a) Description of the duties of the physician hours that the physician will be working.
- (b) The mechanism that will be used to insure that the independent practice is not being done during performance of the usual duties of the house officer as a trainee.
 - 1. Independent practice by the resident physician within the medical center may be done only with the knowledge and consent of the resident's program director and department chairperson.
 - 2. Residents must possess a permanent medical license in the state of Illinois.
 - 3. Residents must be in good standing with the department and the medical center.
 - 4. Residents must be granted privileges by the medical staff to perform the services for which independent practice is being performed. Ordinarily, the physician will have completed training in the area of practice, but under some circumstances equivalent training in the specific privileges will be acceptable. In such cases, the Associate Dean for Graduate Medical Education should approve a request.
 - 5. Residents may be employed or contracted by a private practice entity or Medical Service Plan, but a statement should be available in the employing

department specifying the separation between the billing entity and the hospital.

6. Residents must provide evidence of malpractice coverage that is other than and separate from the coverage usually afforded to house officers.

V. MEDICAL STAFF COMMITTEES

1. Standing Committees and Sub-Committees

- (a) Other than the Executive Committee, the standing committees of the Staff shall be the: (1) Nominating Committee, (2) Quality Committee, (3) Professional Assistance Committee, (4) the Bylaws Review Committee, (5) Credentials Committee, and such other ad hoc committees as may be approved by the Executive Committee from time to time.
- (b) The Chairperson and members of each standing committee are to be appointed annually by the President. Each committee shall have a Chairperson appointed by the President. At his or her discretion, the President may appoint additional members to Standing Committees in addition to those specified in the Medical Staff Bylaws. The Chairperson shall be appointed annually and members are appointed for two years, except where otherwise stated herein. The annual term of each standing committee will begin on July 1st of each year. House Staff members, when applicable, shall be designated by the house staff organization with approval by the President. The Dean, the Chief Medical Officer, the Director for Medical Staff Operations, and the Director of Quality Improvement shall be ex-officio members of all standing committees except the Nominating Committee and the Professional Assistance Committee.
- (c) Meetings of each committee shall be called by the Chairperson as specified in the Medical Staff Bylaws, as indicated by need, or at the request of the President.
- (d) Reports or minutes of each meeting, from all committees with the exception of the Nominating Committee, shall be submitted in writing to the Executive Committee through the President. These reports are usually to be submitted at least ten days prior to the regularly scheduled meeting of the Executive. Such reports will, if no other action is required, be received for information. If action is required, either recommendations will be made or specific action will be taken by the Executive Committee. The original copies of all reports shall be kept on file in the Medical Staff Office.
- (e) Medical Staff Standing Committees and sub-committees may at times use cumulative data on individual physician performance for

patient safety and quality improvement. To protect the rights of physician confidentiality and prevent the inappropriate dissemination of such information, all Medical Staff Committees must maintain strict confidentiality of this material and the Medical Staff Office shall maintain separate and secure files of such information. Such data may be used in the credentialing process if the following process is performed prior to data collection: 1) the Medical Staff Standing Committee has developed specific review criteria which is reviewed by the Medical Staff Quality Committee for relevancy of the data and appropriateness of the criteria and which recommends it to the Executive Committee; 2) the Executive Committee further reviews the appropriateness of the data for credentialing after specific Departmental comments on the review criteria and approves of forwarding this data to the Department Chairperson for use in the credentialing and reappointment process; 3) the individual physician has had the opportunity to review and comment on the review criteria, the cumulative data and his or her individual performance prior to its use in the credentialing and reappointment process. Access to cumulative data on individual physician performance is limited to the Medical Staff Standing Committee which generates these data unless approved for use in the credentialing process in which case access is limited to the individual physician, the physician's Department Chairperson, the Credentials Committee and the Medical Staff Office, limited by its responsibility to secure and when appropriate distribute such data.

- (f) It shall be the responsibility of each standing committee and sub-committee to maintain a document defining its goals, procedures and policies.
- (g) It shall be the responsibility of each standing committee and sub-committee to perform its functions at all sites of the Medical Center.

2. Subcommittees. The following standing subcommittees are subcommittees of the Medical Staff Quality Committee: (1) Medical Records Subcommittee, (2) Utilization Management Subcommittee, (3) Pharmacy and Therapeutics Subcommittee, (4) Transfusion/Blood Usage Subcommittee, and (5) Operative and Invasive Procedure Review Subcommittee. They shall report results of activity on a regular basis to the Medical Staff Quality Committee.

3. Term of Committee Membership and Prior Removal. Unless otherwise specifically provided, a Medical Staff committee member shall continue as such for two years and until a successor is elected or appointed, unless he or she shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving ex officio, may be removed by a majority vote of the Executive Committee. An administrative staff

committee member shall serve for a term equivalent to that of a Medical Staff committee member and until a successor is elected or appointed, unless he or she shall sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Chief Executive Officer of the Medical Center.

4. Vacancies. Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee was made.
5. Meetings. Unless otherwise specifically provided, a Staff committee established to perform one or more of the Staff functions required by the Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.
6. Quorum. Unless otherwise provided, a majority of the voting members of a Staff committee shall constitute a quorum of that committee, and the committee may act upon the vote of a majority of its members at a meeting at which a quorum is present.

A. Membership and Duties of Standing Committees

The membership and duties of each of the standing committees of the Staff shall be as stated in the Medical Staff Bylaws:

1. Medical Records Sub-Committee.
 - (a) Membership. The Committee shall be composed of the Chairperson, at least six Medical Staff representatives including three from Medical Sciences and Services and three from Surgical Sciences and Services and at least two representatives from the Clinical Nursing staff (including at least one from Rehabilitation);, the Associate Vice President from Medical Center administration responsible for the Medical Records Department, one house staff physician, the President of the House Staff Association, Director of Pharmacy, and the director of the Medical Records Department. In addition, the following shall be members ex officio: the Director of the Medical Center's print shop; the Director of the Office of Risk Management; a representative from Hospital Sponsored Ambulatory Care, the HIM representative from Rush Home Care, Director of Clinical Information Systems, Director of Graduate Medical Education, the Privacy Manager, the Supervisor of the Medical Records Satellite office, and the chairs of Clinical Pertinence and Forms sub-committees.
 - (b) Duties. The Committee shall be responsible for maintaining surveillance over the quality of medical records in the Medical Center and for developing policies and regulations to improve the

quality of medical records. For purposes of this section the term “quality of medical records” shall mean completeness, clarity, legibility, efficiency of preparation, availability and storage, and suitability for patient care, teaching, research and use by the Utilization Management Committee, Operative and Invasive Procedure Review Committee, the Medical Staff Quality Committee, and other Staff organizations. The duties of the Committee shall include the following:

- to monitor at least quarterly quality and timeliness of documentation and transfer of patient information throughout the Medical Center;
- to review each medical record or a representative sample of records, to assure that the record(s) reflect: the diagnosis, the results of diagnostic tests, the patient therapy rendered, the condition and progress of the hospitalized patient, and the patient’s condition at discharge;
- to review inpatient psychiatry medical records to assure documentation of special treatment procedures requiring special justification as provided in the rules and regulations: restraint or seclusion, electro-convulsive and other forms of convulsive therapy, surgical procedures used to treat emotional, mental or behavioral disorders, behavior modification procedures utilizing aversive conditioning, and other special treatment procedures for children and adolescents;
- make recommendations regarding the medical record format;
- to review and approve or disapprove all forms to be used in the medical record;
- to monitor monthly delinquent record counts for Staff members and House Staff;
- to provide for completion of the medical records of the patients of physicians who are no longer members of the Staff;
- to develop policies regarding dissemination of medical information in order to protect the confidentiality of records;
- to develop policies regarding appropriate documentation procedures; and
- to perform such other duties as assigned by the Executive Committee.

(c) Meetings. The Committee shall meet monthly at least 10 times per year.

(d) Reports. The Committee shall maintain written reports of its findings, recommendations, actions taken and their result. The Committee shall report its findings to the Executive Committee

through the Medical Staff Quality Committee and to the Medical Center's Performance Improvement Oversight Committee.

2. Utilization Management Sub-Committee.

The Chairperson of the Committee shall be a member of the Medical Staff who as admitting privileges.

- (a) Membership. The Utilization Management Committee shall consist of at least eleven members including: three members from Surgical Sciences and Services; three members from Internal Medicine; one member each from the departments of Neurology, Pediatrics, Emergency Medicine and Psychiatry; and one representative from the House Staff. The Director of Utilization Management shall also be a member.

the Associate Vice President for Finance, the Associate Vice President for Ancillary Services; the Directors of Medical Records, Risk Management,, shall serve as members ex officio. The Committee allows for the appointment of Consultants/Reviewers by the Chair.

- (b) Duties. The Utilization Management Committee shall:

- develop a utilization review plan that is appropriate to the Medical Center and that meets the requirements of law;
- require that the utilization review plan is in effect, known to the Staff members and functioning at all times;
- conduct such studies, take such actions, submit such reports and make such recommendations as are required by the utilization review plan; and
- perform such other duties as assigned by the Executive Committee.

- (c) Meetings. The Committee shall meet monthly at least 10 times per year.

- (d) Reports. The Committee shall maintain written reports of study results and recommendations, and shall report its findings to the Executive Committee through the Medical Staff Quality Committee and to the Medical Center's Performance Improvement Oversight Committee.

3. Operative & Invasive Procedure Review Sub-Committee.

The Chairperson shall be a member of the Medical Staff with admitting privileges..

- (a) Membership. The Operative & Invasive Procedure Review Committee shall be composed of at least five members from the Surgical Sciences and Services including representation from General Surgery, Ob/Gyne, Surgical Sub-Specialties, Pathology and Diagnostic Radiology and at least three members of Medical Subspecialties performing invasive procedures (including one from invasive pediatric).
- (b) Meetings. This Committee shall meet monthly at least 10 times per year.
- (c) Duties. Review is conducted of operative and invasive procedures based on explicit screening criteria approved by the committee, whether or not a tissue specimen was removed for surgical justification and appropriateness of individual. The review of an adequate sample of cases is acceptable as determined by the committee based on the current guidelines.

An evaluation is made in all cases in which a major discrepancy exists between preoperative and post-operative (including pathologic) diagnoses, or which lack sufficient documentation in the medical record to establish the clinical justification. In addition, analysis of aggregate data of specific procedures for patterns and trends may be performed as appropriate. On all cases, the committee shall eventually render a judgment as to the justification of the procedure and communicate that judgment to the appropriate attending physicians and department chairs for use in credentialing and reappointment.

- (d) The Committee shall also report its findings on issues providing opportunities for quality improvement to the appropriate department Chairmen, and the Executive Committee through the Medical Staff Quality Committee. The Committee shall maintain written reports of its findings, conclusions and actions taken and their results.

4. Pharmacy and Therapeutics Sub-Committee.

The Chairperson shall be a Medical Staff member with active admitting privileges; the Secretary of the Committee shall be the Director of the Pharmacy.

- (a) Membership. The Committee shall be composed of at least ten staff members (2 from the IRB), one clinical pharmacist, the director of the Nutrition Consultation Service, the Director of the Infusion Pharmacy, two members of the House Staff, one each from the Medical Sciences and Services and the Surgical Sciences and Services; the Director of the Drug Information Center; the Director of Pharmacy, and one representative each from Medical/Surgical

and Critical Care Nursing. The following shall be ex-officio members: the Director of Risk Management and a representative from the Patient Safety Oversight Committee. The Chair may appoint additional regular members or ex-officio members as necessary

(b) Duties. The Pharmacy and Therapeutics Sub-Committee shall:

- assist in the formulation of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs, biologicals, diagnostic testing materials, and intravenous solution (except blood and blood derivatives) in the Medical Center;
- advise the Medical Staff and the Medical Center Pharmacy on matters pertaining to the choice of available drugs;
- make recommendations concerning drug products to be stocked on the nursing unit floors and by other services;
- develop and revise periodically and publish annually a formulary or drug list for use in the Medical Center;
- review clinical data concerning new drugs products requested for use in the Medical Center;
- receive reports from the Human Investigation Committee of the Medical Center concerning the use and control of investigational drugs and of research in the use of recognized drugs;
- review the appropriateness, safety, clinical effectiveness and cost effectiveness of prescription, preparation, dispensing, administration and monitoring of effects of medications through the analysis of individual or aggregate patterns of drug practice;
- review all significant untoward drug reactions;
- review medication errors for patterns or trends and recommend improvements to promote safety in the administration and handling of drug products;
- promote education and dissemination of information on drug products and drug therapy for appropriate personnel; and
- perform such other duties as assigned by the Executive Committee.

(c) Meetings. This Committee shall meet at least every two months or more often if necessary.

(d) Reports. This Committee shall maintain a record of all activities relating to the Committee's findings, recommendations, actions taken and their result. The Committee shall submit reports and recommendations to the Executive Committee through the Medical Staff Quality Committee and to the Medical Center's Performance Improvement Oversight Committee.

(e) The performance of the above duties may be delegated to standing subcommittees established by the Committee which report to the Committee at least quarterly. The Chairmen of each subcommittee are members of the Pharmacy and Therapeutic Committee. The Chairmen and Members of the subcommittees are appointed by the Committee Chairperson.

(f) Anti-infective Review Subcommittee.

- Membership. The members of each subcommittee shall be appointed. The subcommittee shall have representation from the Section of Infectious Disease, Infection Control and Surveillance Committee, the clinical Laboratory Committee and the Pharmacy Department.
- Duties. The duties of the Anti-infectives Review Subcommittee shall be to: review the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of anti-infectives used in all inpatient care areas of the Medical Center; develop a screening mechanism using clinically valid criteria to identify problems with a specific anti-infectives or category of anti-infectives; evaluate problems identified through the screening process.
- Reports. This subcommittee shall report to the Pharmacy and Therapeutic Committee. The subcommittee shall maintain written reports of studies, recommendations, actions taken and their results.

(g) Adverse Drug Reaction Surveillance Subcommittee/Medication Error Subcommittee

- Membership. This subcommittee shall be representation from at least four members of the Medical Staff, a member of the Department of Pharmacy, and two members of the Nursing Staff.
- Duties. The duties of the Adverse Drug Reaction Surveillance Subcommittee/Medication Error Subcommittee shall be to: provide definition and systematically monitor and review individual events and aggregate data of adverse drug reactions; develop and utilize criteria to identify errors in the prescribing, pharmacy dispensing, nursing (or other health care professional) administration, or transcription of medications to ensure that medications are administered to patients as intended; develop and implement educational programs to correct problems;

make appropriate recommendations to the Pharmacy and Therapeutics Committee based on such review.

- Reports. This subcommittee shall report to the Pharmacy and Therapeutics Committee. This subcommittee shall maintain written reports of studies, recommendations, actions taken and their results.
 - (h) Drug Usage Evaluation Subcommittee/Therapeutic Drug Monitoring Subcommittee
- Membership. This subcommittee shall have representation from at least a) four members of the Medical Staff, b) one member of the Department of Pharmacy, and c) two members of the Nursing Staff.
- Duties. The duties of the Drug Usage Evaluation Subcommittee/Therapeutic Drug Monitoring Subcommittee shall be to: develop and utilize criteria for the ongoing, systematic review of appropriateness, effectiveness, and safety of drug therapy and its outcomes (other than anti-infectives) including the prophylactic, therapeutic and empiric use of drugs, provided a mechanism for monitoring and continuously improving patient care; serve as an educational process for the Medical Staff; identify optimal therapeutic drug monitoring parameters to assess medication efficacy and/or side effects; identify deficiencies in the current therapeutic drug monitoring system and recommend actions to improve the system; education professional staff (nurses, pharmacists physicians) and ancillary personnel (i.e. laboratory technicians) on appropriate therapeutic drug monitoring procedures.
- Reports. This subcommittee shall report to the Pharmacy and Therapeutic Committee. This subcommittee shall maintain written reports of studies, recommendations, actions taken and their results.

7. Transfusion/Blood Usage Sub-Committee.

- (a) Membership. The Committee shall be composed of at least seven members including three members from Surgical Sciences (one from transplant), three members from Medical Sciences, one member from Anesthesiology; and one representative each from Medical/Surgical and Adult Critical Care Nursing, the Director and the Laboratory Manager of the Blood Center.; The Director of Risk Management; shall be ex officio.
- (b) Duties. This Committee shall review and make recommendations concerning methods of collection and use of blood and blood derivatives. The Committee shall:
 - evaluate the appropriateness of all transfusions of whole blood and blood derivatives;

- evaluate all confirmed transfusion reactions;
 - develop or approve policies and procedures regarding distribution, handling, use and administration of blood and blood derivatives;
 - determine whether the transfusion services provided are adequate to meet the patient's needs;
 - review ordering practices for blood and blood products; and
 - perform such other duties as assigned by the Executive Committee.
- (c) Meetings. This Committee shall meet at least once each quarter.
- (d) Reports. This Committee shall maintain written reports of study results, actions taken and their result. The Committee shall submit reports to the Executive Committee through the Medical Staff Quality Committee and to the Medical Center's Performance Improvement Oversight Committee.

VI. DEFINITIONS

Medical Staff Bylaws:

The bylaws establish the relationship between the hospital and its medical staff. The bylaws describe the relationships. The prerogatives, and the obligations between the medical staff and the governing body. Amendments & revisions to the bylaws must be approved by a vote of the majority of the medical staff, as well as the Board of Trustees. The bylaws can be specific or more general in describing its standards. If there are any amendments to the bylaws. These changes are generally voted on twice a year, or in accordance with the requirements of the Medical Staff Bylaws. Amendments may also be approved by mail or electronic ballot or at a special meeting of the Medical Staff. Special meetings of the medical staff may be called at any time upon reasonable notice by the President or by written petition signed by at least twenty percent (20%) of the voting members of the medical staff. If approved by the medical staff: it then goes to the Board of trustees for its approval.

Rules and Regulations:

Rules and regulations of the medical staff provide greater detail than the bylaws and generally pertain to specific processes or circumstances such as member responsibilities. Because the medical staff is responsible for providing one level of care, the issues are often related to care of the patient and tasks surrounding that care. The medical staff rules and regulations usually cross clinical department lines and apply to all members of the medical staff. For example, the medical staff rules and regulations contain provisions relative to admission, transfers, consultations, autopsies and medical records, etc. The medical staff R&Rs should not conflict with or repeat provisions in the bylaws. The process for implementing amendments to the R&Rs has recently changed per Joint Commission

standard MS.01.01.01. In the past, revisions to the R&Rs did not require the approval of the entire medical staff and could be revised or mandated by the medical staff executive committee. However, per the Joint Commission, the medical staff must receive proposed amendments to the R&Rs at least 30 days before (with exception of urgent rules & regulations) the Executive Committee votes on those rules or regulations.

Medical Staff Policies:

Policies and procedures usually outline and describe specific mechanisms to carry out processes. They are administrative in nature and may pertain to non-patient care policies and related procedures. Policies and procedure manuals might outline the credentials review process, define mechanisms, (i.e., dues, conduct, delinquent records, etc.) It is up to the organization to decide the content of its rules and regulations and policies and procedures. The policies and procedures should not conflict with or repeat the provisions of the bylaws or R&Rs. Amendments and changes to the policies and procedures will be binding without obtaining the prior approval of the medical staff so long as such policies are consistent with the MS Bylaws, Rules & Regulations. These revisions go to the medical staff executive committee for approval and. Thereafter, receive the approval of the Board or Trustees.