

THOMASVILLE MEDICAL CENTER

RULES & REGULATIONS

APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE
APPROVED BY THE MEDICAL STAFF
APPROVED BY THE BOARD OF DIRECTORS

April 8, 2003
May 13, 2003
May 20, 2003

REVISIONS:

December 2003
March 2004
September 2004
January 2005
March 2006
June 2006
August 2006
January 2007
February 2007
July 2007
January 2008
June 2008
July 2008
September 2008
May 2009

RULES AND REGULATIONS - TABLE OF CONTENTS

Article 1	ADMISSION AND DISCHARGE OF PATIENTS.....	4
1.1	ADMITTING PATIENTS	4
1.2	RESPONSIBILITIES OF THE MEDICAL STAFF FOR MEDICAL CARE AND TREATMENT.....	4
1.3	PROVISIONAL DIAGNOSIS	4
1.4	EMERGENCY ADMISSIONS.....	4
1.5	PATIENT TRANSFERS WITHIN THE HOSPITAL:	5
1.6	PROTECTION FROM HARM.....	5
1.7	CARE OF POTENTIALLY SUICIDAL PATIENTS	5
1.8	DISCHARGING PATIENTS FROM THE HOSPITAL	6
1.9	HOSPITAL DEATH.....	6
1.10	AUTOPSIES	6
Article 2	MEDICAL RECORDS	8
2.1	CONTENTS OF THE MEDICAL RECORD	8
2.2	HISTORY AND PHYSICAL EXAMINATION.....	9
2.3	PROGRESS NOTES.....	10
2.4	OPERATIVE REPORTS.....	11
2.5	CONSULTATIONS.....	11
2.6	AUTHENTICATION OF MEDICAL RECORDS	12
2.8	USE OF SYMBOLS AND ABBREVIATIONS.....	12
2.9	DISCHARGE SUMMARY	12
2.10	RELEASE OF MEDICAL RECORDS	13
2.11	ACCESS TO MEDICAL RECORDS	13
2.12	RETIRING INCOMPLETE MEDICAL RECORDS	14
2.13	DELINQUENT MEDICAL RECORDS.....	14
Article 3	GENERAL CONDUCT OF CARE	16
3.1	CONSENT	16
3.2	ORDERS	17
3.3	ADMINISTERING MEDICATIONS	18
3.4	CONSULTATION	19
3.5	NEW MEDICAL STAFF MEMBERS.....	20
3.6	SPECIAL CARE UNITS.....	20
3.7	CLINICAL DEPARTMENTS	20
3.8	RIGHT TO APPEAR BEFORE MEDICAL EXECUTIVE COMMITTEE.....	20
Article 4	GENERAL RULES REGARDING SURGICAL CARE	21
4.1	SURGICAL EMERGENCIES.....	21
4.2	ORAL SURGEON AND PODIATRIST'S RESPONSIBILITIES:.....	21
4.3	CONSENTS.....	21
4.4	ANESTHESIA.....	22
4.5	PATHOLOGICAL SPECIMENS.....	22
4.6	COMMENCEMENT OF OPERATIONS.....	22

Article 5 EMERGENCY SERVICES..... 23

 5.1 EMERGENCY DEPARTMENT COVERAGE..... 23

 5.2 EMERGENCY DEPARTMENT RECORDS 24

 5.3 MASS CASUALTIES 24

 5.4 IMMEDIATE CREDENTIALING IN CASE OF MASS DISASTER 26

Article 6 MEDICAL SCREENING EXAMS AND TRANSFERS 28

 6.1 MEDICAL SCREENING EXAM: 28

 6.2 CRITERIA FOR TRANSFER: 29

Article 7 MEDICAL STAFF APPOINTMENTS TO THE BOARD OF DIRECTORS..... 32

Article 8 PHYSICIANS HEALTH AND EFFECTIVENESS POLICY (PHEP) 34

 8.1 PURPOSE: 34

 8.2 MECHANISM FOR IDENTIFICATION AND FAIR ASSESSMENT OF
OCCURRENCES:..... 34

 8.3 TMC PHYSICIANS HEALTH AND EFFECTIVENESS COMMITTEE:..... 36

 8.4 CONFIDENTIALITY 38

 8.5 RIGHTS OF MEDICAL STAFF MEMBERS..... 38

Article 9 ORGANIZED HEALTH CARE ARRANGEMENT (OHCA) 42

Article 10 STANDING ORDERS.....40

 10.1 INR Every 3 Days On Patients Receiving Coumadin40

 10.2 No MD Order Needed for Influenza & Pneumonia Vaccinations.....40

Article 1 ADMISSION AND DISCHARGE OF PATIENTS

1.1 ADMITTING PATIENTS

1.1.1 Only a member of the Medical Staff may admit a patient to the Hospital.

1.1.2 The official admitting policy of the Hospital shall govern all members of the Medical Staff.

1.2 RESPONSIBILITIES OF THE MEDICAL STAFF FOR MEDICAL CARE AND TREATMENT

1.2.1.1 A member of the Medical Staff shall be responsible for: The medical care and treatment of each patient in the Hospital

1.2.1.2 The prompt completion and accuracy of the medical record

1.2.1.3 Necessary special instructions

1.2.1.4 Transmitting reports of the condition of the patient to the referring member of the Medical Staff and to the patient or his or her legally authorized representative.

1.2.2 Transfers to another member of the Medical Staff of admitted patients

1.2.2.1 Whenever the patient's care is transferred to another Medical Staff member:

1.2.2.1.1 An order covering the transfer of responsibility shall be entered on the order sheet of the medical record.

1.2.2.1.2 The transferring member of the Medical Staff is responsible for personally notifying the receiving member of the Medical Staff to ensure that the acceptance of that responsibility is clearly understood.

1.2.2.1.3 The transferring member of the Medical Staff is responsible for dictating or writing a transfer summary covering the care given prior to the transfer should the receiving member of the Medical Staff request that one be completed prior to transfer.

1.3 PROVISIONAL DIAGNOSIS

1.3.1 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

1.4 EMERGENCY ADMISSIONS

1.4.1 In any emergency case in which it appears the patient will have to be admitted to the Hospital, the member of the Medical Staff or designee shall, when possible, first contact the Admissions Department to ascertain whether there is an available bed

1.4.2 Members of the Medical Staff admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the Administration of the Hospital that the said emergency admission was a "bona fide" emergency

1.4.3 The history and physical examination must clearly justify the patient's being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission

1.4.4 A patient to be admitted on an emergency basis who does not have a private member of the Medical Staff as a physician who does not already have a relationship with a member may request any member of the Medical Staff in the applicable Department to attend to him

1.4.4.1 Where no such arrangement is made, a member of the Active or Provisional Active Staff on duty in the Department will be assigned to the patient, on a rotation basis

1.4.4.2 The Chief of the Department or designee shall provide a schedule for such assignment

1.4.4.3 Failure of a member of the Medical Staff to meet this requirement may result in disciplinary action

1.4.5 Each member of the Medical Staff who is temporarily out of the immediate vicinity, shall name a member of the Medical Staff who may be called to attend his/her patients in an emergency, or until he/she arrives.

1.4.5.1 In case of failure to name such associate, the Chief of the Department shall have authority to call any member of the Active or Provisional Staff in such an event.

1.4.5.2 In the absence of the Chief of Department this authority shall pass to the Chief of Staff, the Chief of Staff-Elect, or to the Administrator on call in this order.

1.4.5.3 Failure of a member of the Medical Staff to meet this requirement may result in disciplinary action.

1.5 PATIENT TRANSFERS WITHIN THE HOSPITAL:

1.5.1 Transfer priorities from one area of the Hospital to another shall be as follows:

1.5.1.1 Emergency Room to appropriate patient bed.

1.5.1.2 From Obstetric patient care area (unit) to general care area, when medically indicated.

1.5.1.3 From Intensive Care Units to general care area.

1.5.1.4 From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

1.5.2 No patient will be transferred within the Hospital without such transfer being approved by the responsible member of the Medical Staff, and notification of the patient and/or family when practical.

1.6 PROTECTION FROM HARM

1.6.1 The admitting members of the Medical Staff shall provide 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

1.7 CARE OF POTENTIALLY SUICIDAL PATIENTS

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:

1.7.1 The patient, under the age of 55, shall be referred, if possible to another institution where suitable facilities are available.

1.7.2 When transfer is not possible, the patient may be admitted to a general area of the Hospital, and, as a temporary measure, psychiatric screens may be placed on the windows of the patient's room.

1.7.2.1 If a patient determined to be suicidal is to be placed in a general area of the Hospital, reliable family members or friends must be present 24 hours a day to stay with the patient.

1.7.2.1.1 Nursing staff will relieve the family and friends for 30 minute periods 3 times a day so that they may obtain meals.

1.7.2.1.2 Should no reliable family member or friend be available, as soon as the patient is stable (see Rules & Regulations 6.2.5.), the patient will be transferred to another institution where suitable facilities are available

1.7.3 Any patient known or suspected to be suicidal must be offered consultation by a member of the Psychiatric Staff and that such services were at least offered must be documented in the patient's record.

1.8 DISCHARGING PATIENTS FROM THE HOSPITAL

1.8.1 Patients shall be discharged only on the written order of the attending member of the Medical Staff or by the consulting physician with the approval of the attending physician..

1.8.2 Should a patient leave the Hospital against the advice of the attending member of the Medical Staff, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

1.9 HOSPITAL DEATH

1.9.1 In the event of a Hospital death, the deceased shall be pronounced dead by the attending member of the Medical Staff or his/her designee within a reasonable time.

1.9.2 The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or his/her designee.

1.9.3 Policies with respect to release of dead bodies shall conform to the laws of the State of North Carolina.

1.10 AUTOPSIES

1.10.1 It shall be the duty of all Medical Staff members to attempt to secure consent to autopsies when indicated.

1.10.2 All physicians will follow the statues/rules with guidelines concernig the N.C. Medical Examiners system to define and properly report Medical Examiner cases.

1.10.3 An autopsy may be performed only with a written consent, signed in accordance with laws of the State of North Carolina and the Novant Health informed consent policy.

- 1.10.3.1 The Medical Staff member is responsible for obtaining permission for autopsy from the patient's family or guardian and for informing the pathologist of the need for an autopsy.**
- 1.10.3.2 Documentation of verbal consent must be incorporated into the physician's progress notes.**
- 1.10.3.3 A signed authorization form must be placed in the chart.**
- 1.10.3.4 The Medical Examiner may order an autopsy without the order of the attending physician.**

1.10.4 All autopsies shall be performed by the Hospital pathologist, or by a pathologist delegated this responsibility by the Hospital with the approval of the Medical Staff.

1.10.5 When an autopsy is performed the provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within sixty (60) days.

1.10.6 Autopsies are recommended in the following situations:

- 1.10.6.1 Deaths in which an autopsy may help explain unknown and unanticipated medical complications**
- 1.10.6.2 Deaths in which the cause is not known with certainty on clinical grounds**
- 1.10.6.3 Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death, and provide reassurance to them regarding the same**
- 1.10.6.4 Unexpected or unexplained deaths occurring during or following any oral surgical podiatric, medical or surgical diagnostic procedure(s) and/or therapy(s)**
- 1.10.6.5 Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards**
- 1.10.6.6 Sudden, unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction**
- 1.10.6.7 Natural deaths that are subject to but waived by a forensic jurisdiction such as the following:**
 - 1.10.6.7.1 Persons dead on arrival at Hospital,**
 - 1.10.6.7.2 Deaths occurring in Hospital within 24 hours of admission,**
 - 1.10.6.7.3 Deaths in which the patient sustained or apparently sustained an injury while Hospitalized**
- 1.10.6.8 Deaths resulting from high-risk infectious and contagious diseases**
- 1.10.6.9 All obstetric deaths**
- 1.10.6.10 All neonatal and pediatric deaths**
- 1.10.6.11 Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.**
- 1.10.6.12 Deaths known or suspected to have resulted from environmental or occupational hazards**

Article 2 MEDICAL RECORDS

2.1 AUTHORIZED ENTRIES

***June 2008**

2.1.1 All clinical entries in the patient's medical record shall be accurately dated and timed, its author identified, and signed by the author to verify that it is complete, accurate, and final. Authorized persons to make entries are:

Medical Staff members and their credentialed, employed allied health professionals, Cardiopulmonary Services, Clinical Dieticians, Radiology, Laboratory, Nursing Service, Pharmacy, Physical Therapy, Speech Therapy, Occupational Therapy, Case Management, Discharge Planning, Social Worker, Chaplain Services, contract personnel under above departments, and students of approved programs with instructor guidance.

2.2 CONTENTS OF THE MEDICAL RECORD

2.2.1 The attending member of the Medical Staff shall be responsible for the preparation of a complete and legible medical record for each patient. It shall contain sufficient information to justify the diagnosis, verify the treatment and document the course of treatment and results accurately. The following information shall be included:

- 2.2.1.1 Identification data (name, address, age, sex) and, when the identification data is not obtainable, the reason for such**
- 2.2.1.2 Date and time of admission and discharge**
- 2.2.1.3 Medical history**
 - 2.2.1.3.1 Chief complaint**
 - 2.2.1.3.2 History of the present illness**
 - 2.2.1.3.3 Relevant past, social and family histories**
- 2.2.1.4 Reports of relevant physical examinations**
- 2.2.1.5 Diagnostic and therapeutic orders**
- 2.2.1.6 Reports of procedures, tests and their results**
- 2.2.1.7 Pathological findings**
- 2.2.1.8 Provisional or admitting diagnosis**
- 2.2.1.9 Evidence of appropriate informed consent or a written statement explaining why consent was not obtained**
- 2.2.1.10 Clinical observations, including results of therapy**
- 2.2.1.11 Record of medication and treatment administration**
- 2.2.1.12 Progress notes of all disciplines**
- 2.2.1.13 Conclusions at termination of Hospitalization or evaluation and treatment**
- 2.2.1.14 All relevant diagnosis established by the time of discharge**
- 2.2.1.15 Consultation reports**
- 2.2.1.16 Surgical record, including anesthesia record, pre-operative diagnosis, surgeon's operative report and post-operative orders**

2.2.1.17 *Instructions given to the patient and/or family to include medications, diet, physical limitations, and follow up care*

2.2.1.18 *Autopsy findings, if performed*

2.3 HISTORY AND PHYSICAL EXAMINATION *March 2004, March 2006

2.3.1 *A complete history and physical examination shall be recorded within 24 hours of admission.*

2.3.1.1 *A history and physical must be performed and in the medical record of every patient admitted.*

2.3.1.1.1 The full history and physical examination must have been performed within 30 days prior to the admission or within 24 hours after the admission.

2.3.1.1.2 If the history and physical examination was performed and recorded within 30 days of admission, the history and physical should be placed in the patient's medical record within 24 hours after admission. Prior to the admission, the patient should be re-assessed to update any components of the patient's current medical status that may have changed since the prior history and physical or to address any areas where more current data is needed, confirming the necessity for the care and that the history and physical examination is still current.

2.3.1.1.2.1 *This assessment is required regardless of whether or not there were any changes in the patient's status.*

2.3.1.1.3 In any emergency, the member of the Medical Staff shall make at least a comprehensive note regarding the patient's condition.

2.3.1.2 ***A history and physical must be performed and in the medical record of every patient prior to any procedure***

2.3.1.2.1 The full history and physical examination must have been performed within 30 days prior to the procedure.

2.3.1.2.2 If the history and physical examination was performed and recorded within 30 days of the procedure, the physician must update any components of the patient's current medical status that may have changed since the prior history and physical or to address any areas where more current data is needed, confirming the necessity for the care or procedure, and that the history and physical examination is still current.

2.3.1.2.2.1 *This assessment is required regardless of whether or not there were any changes in the patient's status*

2.3.1.2.2.2 *If the patient is to have a surgical or invasive procedure in the Operating Room and the history and physical examination is within the 30 day time frame, the patient will be kept in the outpatient area until the history and physical is updated.*

2.3.1.2.2.3 *If the patient is to have an invasive procedure in the Endoscopy Suite and the history and physical is within 30 days of the procedure, the patient may be brought to the Endoscopy suite, but no anesthesia will be administered until the physician updates the history and physical. If the patient does not have a history and physical within 30 days of surgery or invasive procedure, the patient will remain in the outpatient area until the physician has completed the history and physical.*

2.3.1.2.3 In any emergency medical condition, the member of the Medical staff shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery or diagnostic procedure.

2.3.2 ***This report should include all pertinent findings resulting from an assessment of all the systems of the body.***

2.3.3 ***An Abbreviated Clinical Form must include:***

2.3.3.1 ***Indications/symptoms to justify any surgical procedures;***

2.3.3.2 ***A list of current medications and dosages;***

2.3.3.3 ***Any known allergies including medication reactions;***

2.3.3.4 ***Existing comorbid conditions;***

2.3.3.5 A physical examination reflecting the type of anesthesia if planned and/or given as follows:

2.3.3.5.1 No Anesthesia, topical, local or regional block

2.3.3.5.1.1 An assessment of mental status; and

2.3.3.5.1.2 An examination specific to the procedure proposed to be performed;

2.3.3.5.2 Moderate Sedation (IV Sedation)

2.3.3.5.2.1 The requirements as specified for no anesthesia, topical, local, or regional block as specified above, and

2.3.3.5.2.2 An examination of the heart and lungs by auscultation;

2.3.3.5.3 General, spinal or epidural anesthesia:

2.3.3.5.3.1 The requirements for intravenous sedation as specified above, and

2.3.3.5.3.2 An assessment and written statement about the patient's general condition

2.3.4 If a history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a reasonably durable and legible copy of these reports may be used in the patient's medical record in lieu of the admission or pre-procedure history and report of the physical examination, provided these reports were authenticated by a member of the Medical Staff.

2.3.4.1 In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

2.3.4.2 To be acceptable, outside records should be in a form approved by the Hospital and should be compatible with its current medical records system.

2.3.5 Within 24 hours of admission, there must be a legible note written by the Medical Staff member on the chart stating the reason for admission.

2.3.6 The medical history and physical examination may be delegated to a physician's assistant or an advance practice nurse practitioner if:

2.3.6.1 The physician's assistant or advance practice nurse practitioner has received specific training and has demonstrated competence to perform an appropriate history and physical examination

2.3.6.2 The medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns and retains accountability for the patient's medical history and physical examination

2.3.6.3 The attending Medical Staff member shall countersign (authenticate) the history, physical examination, and preoperative note within 7 days or before the patient undergoes major diagnostic or therapeutic intervention, whichever is sooner, when they have been recorded by a physician's assistant or nurse practitioner

2.3.7 OBSTETRICAL RECORDS

2.3.7.1 The current obstetrical record shall include a complete prenatal record

2.3.7.2 The prenatal record will be the original of the attending member of the Medical Staff'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.

2.3.7.3 Completion of the OB-Admitting Form will be accepted

2.4 PROGRESS NOTES

2.4.1 Pertinent legible progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability.

2.4.2 *Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.*

2.4.3 *Progress notes shall be written at least daily*

2.5 OPERATIVE REPORTS

2.5.1 *Operative reports shall include a detailed account of the findings as well as the details of the surgical technique*

2.5.2 *Operative reports should be written (or dictated) immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's medical record*

2.5.3 *An operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient.*

2.5.3.1 *This operative progress note should contain at minimum comparable operative report information. These elements include;*

2.5.3.1.1 Name of primary surgeon and assistants

2.5.3.1.2 Findings

2.5.3.1.3 Technical procedures used

2.5.3.1.4 Specimens removed

2.5.3.1.5 Postoperative diagnosis

2.5.3.1.6 Estimated blood loss.

2.5.3.2 *Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care".*

2.5.3.2.1 If the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care

2.5.4 *The Medical Executive Committee may take appropriate action against habitual violators of this requirement.*

2.6 CONSULTATIONS

**May 2009*

Deleted:

Deleted: January 2007

2.6.1 *Attending physicians are responsible for requesting consultant services when medically indicated.*

2.6.2 *An order for the consultation must be written in the patient record. The order should specify the medical indication for the consultation.*

2.6.3 *The order should specify whether the consultation is "routine" or "urgent" as defined below:*

2.6.3.1 *Routine Consultation is defined as a non-urgent need for consultation services. The consultant is expected to see the patient within 24 hours. Physician to physician is the preferred method of contact but not required. The request for a routine consultation may be transmitted by ancillary services, after the appropriate order has been written by the attending physician. Valid contact information must be provided by the attending physician requests the consult, in the event the consulting physician would like further information and feedback on the case.*

Deleted:

Deleted:

Deleted: a nurse or ward secretary

2.6.3.2 **Urgent Consultation** is defined as a clinical need for consultation that cannot wait 24 hours. **The physician or appointed designee must perform the consult with in 12hrs of the urgent consult request by the attending physician.** The attending physician will specify in the order that the consultation is urgent, and will contact **directly** the consultant physician to describe the clinical problem to be addressed. In the event that the consultant **physician or designated mid-level provider** cannot see the patient on an urgent basis, the consultant may choose to assist the attending physician by discussing diagnostic and/or therapeutic options that may stabilize the patient until the consultation can be completed. The consultant physician should not be asked to give orders on a patient he/she has not examined, and thus it will be the attending physician's responsibility to order any tests or treatment prior to the consultant seeing the patient.

2.6.4 Consultations shall show:

2.6.4.1 Evidence of a review of the patient's record by the consultant who will be a member of the Medical Staff

2.6.4.2 Pertinent findings on examination of the patient

2.6.4.3 The consultant's opinion and recommendations

2.6.5 This report shall be made a part of the patient's record.

2.6.6 When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation, and the operating surgeon shall be responsible to see that the consultation record is present on the patient's record.

2.6.7 In the event of known or suspected suicidal attempts, that consultation services were at least offered must be documented in the patient's record.

2.7 AUTHENTICATION OF MEDICAL RECORDS ***September 2008**

2.7.1 All patient medical records entries must be dated, timed, and authenticated promptly by the ordering practitioner. Signature stamps will not be used.

2.8 USE OF SYMBOLS AND ABBREVIATIONS

2.8.1 Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Health Information Management Department.

2.8.2 Final diagnosis and operative procedures shall be recorded in full, without the use of symbols or abbreviations,

2.9 DISCHARGE SUMMARY

2.9.1 A discharge clinical resume (summary) shall be written or dictated on all medical records of patients Hospitalized over forty-eight (48) hours.

2.9.2 In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end results,

and shall include specific reference to the discharge instructions to the patient regarding physical limitations, diet, and medications.

2.9.3 *The responsible member of the Medical Staff shall authenticate all summaries*

2.9.4 *Final diagnosis and operative procedures shall be recorded in full, dated and signed by the responsible member of the Medical Staff at the time of discharge of all patients, except in the case of delayed autopsy or laboratory reports. This will be deemed equally as important as the actual discharge order.*

2.9.5 *When an autopsy is performed, the provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within sixty (60) days.*

2.9.6 *If a dispute arises as to the identify of the attending member of the Medical Staff or to whose responsibility it is to complete the medical record, the attending member of the Medical Staff will be the member of the Medical Staff who wrote or dictated the admission orders.*

2.10 RELEASE OF MEDICAL RECORDS

***June 2008**

2.10.1 *Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.*

2.10.2 *Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.*

2.10.3 *All records are the property of the Hospital and shall not otherwise be taken out of the Hospital without permission of the President.*

2.10.4 *In case of readmission of a patient, all previous records shall be available for the use of the attending member of the Medical Staff.*

2.10.4.1 *This shall apply whether the patient is attended by the same member of the Medical Staff or by another.*

2.10.5 *Unauthorized removal of charts from the Hospital is grounds for suspension of the member of the Medical Staff for a period to be determined by the Medical Executive Committee of the Medical Staff.*

2.10.6 *If any member of the Medical Staff receives a subpoena, court order or other request for Hospital medical records, the subpoena, court order or other request shall be provided to the Health Information Department for review and response.*

2.11 ACCESS TO MEDICAL RECORDS

2.11.1 *Free access to all medical records of all patients shall be afforded to members of the Medical Staff consistent with state and federal law*

regarding the protection of individually identifiable health information.

2.11.1.1 The Chief of the appropriate Department shall approve all such projects before records can be studied.

2.11.2 Subject to the discretion of the President, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

2.12 RETIRING INCOMPLETE MEDICAL RECORDS *June 2006

2.12.1 Circumstances may arise which prevent the completion of a medical record. Should this occur, the chart may be retired. Retirement means filing of the record in the incomplete state. The possible reasons for retirement are:

2.12.1.1 Death of the responsible physician

2.12.1.2 Permanent unavailability of the person responsible or completion of the record

2.12.1.3 Refusal of former staff members to complete records

2.12.1.3.1 In this case, the departing physician has 30 days from his date of resignation to complete all records. Failure to complete the records will automatically result in a report being made to the NC Medical Board and/or other regulatory bodies including the Center for Medicare and Medicaid services.

2.12.2 Charts will be retired after the following procedures are completed:

2.12.2.1 Management of Information Team must approve

2.12.2.2 A statement of the reason for retirement will be attached to the record.

2.12.2.3 A physician member of the Lead Team III (Management of Information) will sign the statement prior to its inclusion in the chart.

2.13 DELINQUENT MEDICAL RECORDS ~~May 2009~~

Deleted: * March 2006

2.13.1 All incomplete Medical Records will be considered delinquent on the thirtieth (30th) day post discharge or patient death.

2.13.2 Each week on Tuesday by 12:00 Noon

2.13.2.1 A list of all incomplete records (including records which are and are not delinquent) will be placed in the physician's mailbox in the Medical Staff Lounge with delinquent (>30 days old) records highlighted in orange.

2.13.2.2 The names of the members of the Medical Staff who have delinquent (>30 days old) records will be placed on a delinquent list by department and posted in the Medical Staff Lounge with delinquent records highlighted in orange.

2.13.3 Each week on Thursday by 12:00 noon:

2.13.3.1 The names of the members of the Medical staff who still have delinquent (>30 days old) records, highlighted in orange will be forwarded to the Chief of each service who will contact these physicians. The Chief of Staff will also be contacted.

2.13.3.2 Failure to complete all delinquent records by the following Tuesday morning at 12:00 Noon will result in temporary suspension from admitting, consulting, or scheduling any inpatients or outpatients. The suspension will remain in effect until all delinquent

records are completed (including signatures on delinquent records dictated). A physician will not be suspended if there is documentation that the physician signed in to Medical Records and completed all available charts within 5 working days of alleged delinquency. The physician will have an additional 5 days to complete the records. If the records are still incomplete after the 5 day notification, the health information department will notify the physician in writing that his privileges have been suspended until all records have been completed. Notification of suspension will be given to Admitting, Emergency Department, Surgical Services, Administration, Chief of Service and Chief of Staff. New hospital admissions, consultations and procedures will fall to the respecting practice in which the physician is enrolled. If a solo practitioner, this responsibility will fall to the Chief of Service to attempt to find coverage. Following three (3) such suspensions within that calendar year, the Medical Staff Coordinator will in turn report the suspensions to the North Carolina Medical Board per NC GS 90-14-13.

2.13.3.3 If a physician remains on the suspension list for 30 days, he will be reported to the Medical Executive Committee for action.

2.13.3.4 Suspension must be reported to the National Practitioner Data Bank on day 31 of the suspension.

2.13.4 The process noted above may be postponed during times when the member of the Medical Staff is physically unable to complete records (out of town; illness). It is the duty of the physician to notify the Health Information management Department when this occurs.

Article 3 GENERAL CONDUCT OF CARE

3.1 CONSENT

3.1.1 An admission consent and authorization form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission

3.1.2 This general consent does not replace the requirement for informed consent to be obtained by the treating physician.

3.1.3 Written, signed, and witnessed informed consent shall be obtained prior to surgery or any invasive diagnostic procedure in compliance with the Novant informed consent policy.

3.1.4 Emergency treatment may be rendered to a minor without consent,

3.1.4.1 In situations where a medical screening examination is being performed on a minor to determine if an emergency medical condition exists

3.1.4.2 A parent, guardian, or person standing in loco parentis to the child cannot be located or contacted with reasonable diligence during the time within which the minor needs to be treated

3.1.4.3 Where the identity of the child is unknown

3.1.4.4 Where the necessity for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the child's life

3.1.4.5 Where an effort to contact a parent, guardian or person standing in loco parentis to the child would result in a delay that would seriously worsen the physical condition of the child

3.1.4.6 Where the parents refuse to consent to treatment and the necessity for immediate medical treatment is so apparent that the delay required to obtain a court order would endanger the child's life or seriously worsen the child's physical condition

3.1.4.7 These circumstances should be fully explained on the patient's medial record, with at least one witness

3.1.4.8 A consultation with another member of the Medical Staff in such instances is required before any treatment or the emergency operative procedure is performed on a minor.

3.1.5 In emergencies, treatment may be rendered to an adult without consent only if the following conditions are present:

3.1.5.1 The member of the Medical Staff has determined that the patient is in need of immediate treatment

3.1.5.2 The patient is unable to give consent

3.1.5.3 No representative of the patient is available to give consent on behalf of the patient or the process of obtaining consent would result in an unacceptable delay in the treatment of the patient

3.1.5.4 The proposed treatment is limited to that necessary to treat the emergency; and

3.1.5.5 There is no evidence that the patient would oppose the treatment

3.1.5.6 Physicians should document in the record the nature of the emergency and the decision to treat without consent.

3.2 ORDERS

**December 2003, July 2007, January 2008, June 2008*

3.2.1 All orders shall be in writing, dated and timed.

3.2.2 Verbal orders shall be taken and transcribed in the patient's medical record by qualified persons functioning within their scope of practice. This includes:

- 3.2.2.1 Registered nurses**
- 3.2.2.2 Licensed practical nurses**
- 3.2.2.3 Licensed physical therapists,**
- 3.2.2.4 Graduate respiratory therapists and technicians**
- 3.2.2.5 Occupational therapists**
- 3.2.2.6 Vocational evaluators**
- 3.2.2.7 Licensed Speech-Language Pathologists**
- 3.2.2.8 Psychologists**
- 3.2.2.9 Audiologists**
- 3.2.2.10 Recreational therapists**
- 3.2.2.11 Pharmacists**
- 3.2.2.12 Radiologic technologists and nuclear medicine technologists**
- 3.2.2.13 Registered licensed dieticians**
- 3.2.2.14 Laboratory technicians**
- 3.2.2.15 Social workers**
- 3.2.2.16 Admitting office personnel**
- 3.2.2.17 Certified medical assistants**
- 3.2.2.18 Registered licensed dieticians**

3.2.3 Physicians, oral surgeons, podiatrists, optometrists, advance practice nurse practitioners and physician's assistants may order medications according to the privileges granted.

3.2.4 Verbal orders for medications may be accepted only by:

- 3.2.4.1 Registered nurses,**
- 3.2.4.2 Licensed practical nurses,**
- 3.2.4.3 Graduate respiratory therapists and technicians**
- 3.2.4.4 Pharmacists**
- 3.2.4.5 Radiologic technologists and nuclear medicine technologists**
- 3.2.4.6 Certified medical assistants**

3.2.5 The documentation of the verbal order shall include:

- 3.2.5.1 The date**
- 3.2.5.2 Time**
- 3.2.5.3 Name of responsible member of the Medical Staff**
- 3.2.5.4 Full legible signature of the person taking the order**

3.2.6 A responsible member of the Medical Staff shall authenticate all verbal orders.

3.2.6.1 Verbal and telephone orders must be authenticated within 48 hours

3.2.7 The following verbal orders must be signed within twenty-four (24) hours:

3.2.7.1 Restraints – orders for restraints on behavioral health patients within 1 hour after a fact to face encounter (refer to Hospital policy on restraints)

3.2.7.2 DNR

3.2.7.3 Chemotherapeutic orders

3.2.7.4 Investigational drugs

3.2.7.5 Others as defined by the Medical Executive Committee.

3.2.8 Faxed orders will be honored upon receipt, provided the responsible member of the Medical Staff has signed the order.

3.2.9 Orders by physician's assistants and advance practice nurse practitioners must be authenticated within 7 days by the attending physician

3.2.10 All previous orders are canceled when patients go to surgery

**3.2.11 Protocols and Order Sets
*February 2007**

3.2.11.1 The Medical Executive Committee approves all protocols, which healthcare professionals are authorized to implement as the patient's condition indicates. Protocols do not require the physician's signature in the chart.

3.2.11.2 Order sets are formulated and approved by each section of the Medical Staff. Subsequently, they are reviewed by the Medical Staff Quality Management Committee, which makes a recommendation for approval/disapproval to the Medical Executive Committee. The MEC gives final approval for each order set. All order sets require a physician's signature in the chart.

3.3 ADMINISTERING MEDICATIONS

3.3.1 Medication may be administered by physicians, oral surgeons, podiatrists, optometrists and the following professionals in the performance of their defined duties:

3.3.1.1 Nurses and nursing students

3.3.1.2 Certified medical assistants

3.3.1.3 Medical technologists

3.3.1.4 Radiological, radiation and nuclear medicine technologists

3.3.1.5 Respiratory therapists

3.3.1.6 Students under supervision

3.3.1.7 Physical therapists

3.3.1.8 Nurse anesthetists

3.3.1.9 Physician assistants

3.3.1.10 *Advance practice nurse practitioner*

3.3.1.11 *Optometrists*

3.3.2 *All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations.*

3.3.2.1 *Drugs for bona fide clinical investigations may be exceptions.*

3.3.2.2 *These shall be used in full accordance with the Statement Of Principles Involved In The Use Of Investigational Drugs In Hospitals and all regulations of the Federal Drug Administration.*

3.3.2.3 *In urgent situations, drugs may be obtained from outside sources until considered by the Medical Staff Quality Management Committee.*

3.4 CONSULTATION

3.4.1 *Any qualified member of the Medical Staff with clinical privileges in this Hospital can be called for consultation within his area of expertise.*

3.4.1.1 *If asked to consult by another member of the Medical Staff, the physician has an obligation to either complete the consultation or find a similar qualified physician who will complete the consultation*

3.4.2 *Except in an emergency, consultation is recommended in the following situations:*

3.4.2.1 *When the patient is not a good risk for operation or treatment;*

3.4.2.2 *When the diagnosis is obscure after ordinary diagnostic procedures have been completed;*

3.4.2.3 *Where there is doubt as to the choice of therapeutic measures to be utilized;*

3.4.2.4 *In unusually complicated situations where the specific skills of another member of the Medical Staff may be needed;*

3.4.2.5 *In instances in which the patient exhibits severe psychiatric symptoms, overdose, or suicidal attempts;*

3.4.2.6 *When requested by the patient or his family.*

3.4.3 *A satisfactory consultation includes examination of the patient and the patient's medical record.*

3.4.4 *A written opinion and recommendations signed by the consultant must be included in the medical record.*

3.4.5 *When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.*

3.4.6 *It shall be the policy of the Thomasville Medical Center Medical Staff that consultations with prominent and outstanding physicians residing outside the community be permitted. In such cases, temporary privileges shall be granted.*

3.4.7 *The attending member of the Medical Staff is primarily responsible for requesting consultation when indicated and for calling in a qualified*

consultant. He/she will provide written authorization to permit another attending member of the Medical Staff to attend or examine his patient, except in an emergency.

3.5 NEW MEDICAL STAFF MEMBERS

3.5.1 A notice shall be published by the Secretary of the Medical Staff of all new members and their status in the various Departments and shall be placed on the Bulletin Board in the Physicians' Lounge.

3.6 SPECIAL CARE UNITS

3.6.1 Special Care Units may develop and follow their own policies after approval by the Medical Executive Committee of the Medical Staff.

3.7 CLINICAL DEPARTMENTS

3.7.1 Clinical Departments may develop and follow their own policies as approved by the Medical Executive Committee of the Medical Staff.

3.8 RIGHT TO APPEAR BEFORE MEDICAL EXECUTIVE COMMITTEE

3.8.1 Any member of the Medical Staff who feels that the Bylaws, Rules and Regulations are being infringed upon shall have the privilege of appearing before the Medical Executive Committee, at any regular meeting, provided he notifies the Chief of Staff forty-eight (48) hours prior to the meeting, and shall document his case. It shall be the duty of the Chief of Staff to see that any proven violation is corrected.

Article 4 GENERAL RULES REGARDING SURGICAL CARE

4.1 SURGICAL EMERGENCIES

4.1.1 Except in emergencies, the preoperative diagnosis, history and physical and required laboratory tests must be present in a written form on the patient's medical record prior to any surgical procedure or surgical or invasive procedure. (see Article 2.2.1)

4.1.1.1 A dictated but not yet transcribed history and physical is not sufficient

4.1.2 If not recorded, the operation or procedure shall be canceled unless the attending member of the Medical Staff states in writing that such delay would be detrimental to the patient.

4.1.3 In any emergency, the member of the Medical Staff shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery or surgical or invasive procedure.

4.2 ORAL SURGEON AND PODIATRIST'S RESPONSIBILITIES:

4.2.1 A detailed oral surgical or podiatric history justifying Hospital admission;

4.2.2 A detailed description of the oral cavity or foot/ankle and a preoperative diagnosis;

4.2.3 A complete operative report, describing the findings and technique

4.2.4 In cases of extraction of teeth, the oral surgeon shall clearly state the number of teeth and fragments removed.

4.2.5 Progress notes as are pertinent to the oral condition.

4.3 CONSENTS

4.3.1 Written, signed, and witnessed informed consents shall be obtained prior to surgery or any potentially surgical or invasive procedure in compliance with Novant informed consent policy.

4.3.2 If the patient is a competent and conscious adult, the patient must sign the consent form.

4.3.3 If the patient is unconscious and consent cannot be obtained from next of kin or other appropriate party, the rules as written in 3.14 and 3.15 of these Rules and Regulations will apply.

4.3.3.1 Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained.

4.3.3.2 If two or more specific procedures are to be carried out at the same time, and this is known in advance, they may all be described and consented to on the same form.

4.4 ANESTHESIA

4.4.1 Anesthesia personnel shall maintain a complete anesthesia record to include evidence of pre-anesthetic examination, consent to anesthesia, intra-operative anesthesia record, and post-anesthetic follow-up of the patient's condition.

4.5 PATHOLOGICAL SPECIMENS

4.5.1 All tissues removed at the operation shall be sent to the Hospital pathologist who, referring to the current list of specimens that usually require only a microscopic examination, shall make such examination as he may consider necessary to arrive at a tissue diagnosis.

4.5.2 His/her authenticated report shall be made a part of the patient's medical record.

4.6 COMMENCEMENT OF OPERATIONS

4.6.1 Surgeons, oral surgeons, podiatrists, and any physician credentialed to perform endoscopy shall be in the operating room or endoscopy suite and ready to commence operation or endoscopic procedure at the time scheduled.

4.6.2 The operation or endoscopy may be canceled if the operating surgeon, oral surgeon, podiatrist or endoscopist is not in the operating room or endoscopy suite within fifteen (15) minutes after surgery is scheduled to commence.

Article 5 EMERGENCY SERVICES

5.1 EMERGENCY DEPARTMENT COVERAGE

*January 2005, July 2007, July 2008

- 5.1.1 *The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department.***
- 5.1.2 *This shall be in accord with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians, oral surgeons, and podiatrists who render emergency care.***
- 5.1.3 *The duties and responsibilities of all personnel serving patients within the Emergency Department of the Hospital shall, in all cases, be in accordance with policies and procedures established by the Medical Executive Committee of the Medical Staff***
- 5.1.4 *All patients presenting to the Emergency Department must have a medical screening by a physician, advanced practice nurse practitioner, physician's assistant or registered nurse prior to discharge as specified in Article 6 of these Rules and Regulations.***
- 5.1.5 *Emergency unassigned call will switch at 8:00 AM unless mutually agreed upon by the physicians involved.***
- 5.1.6 *The Emergency Department shall maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients in accordance with the resources available to the hospital, including the availability of on-call physicians. The on-call list may not include physician group names; rather, it must include the names of individual physicians.***
- 5.1.7 *Each hospital department and division, through its Chairperson, shall be responsible for establishing unassigned call lists to provide Emergency Room coverage for Thomasville Medical Center. If a particular specialty is not available, the Chairperson is responsible for communicating with the Emergency Room.***
- 5.1.8 *On-call physicians shall respond to pages or phone calls from the Emergency Department within thirty (30) minutes***
- 5.1.9 *A determination as to whether the on-call physician must come to the hospital to physically assess the patient in the emergency department is the decision of the treating Emergency Room physician. If the Emergency Room physician requests that the on-call physician come to the hospital, the on-call physician should present to the emergency room within forty-five (45) minutes of being requested, or within a timeframe at the discretion of the Emergency Room physician based on the clinical presentation of the patient.***

Deleted:

Formatted: Font: 14 pt, Bold, Italic, Word underline

Formatted: Strikethrough

Deleted:

Deleted:

5.1.10 On-call physicians who chose to schedule elective surgery while on call or who take call simultaneously for more than one hospital are responsible for notifying the Emergency Department regarding back-up coverage or other arrangements that should be made in the event that the on-call physician is needed.

5.1.11 If the Emergency Room physician is unable to reach the on-call physician or if the on-call physician refuses to come to the hospital after being asked by the Emergency Room physician to come in, the Chief of the Department or Service and/or the Administrator on Call shall be contacted. This same procedure shall be followed if the on-call physician is unable to respond because of situations beyond his or her control.

5.1.12 Failure of an on-call physician to fulfill his or her call responsibilities is a violation of these Rules and Regulations.

5.2 EMERGENCY DEPARTMENT RECORDS

5.2.1 An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:

5.2.1.1 Adequate patient identification;

5.2.1.2 Information concerning the time of the patient's arrival, means of arrival;

5.2.1.3 Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital;

5.2.1.4 Description of significant clinical, laboratory, and roentgenologic findings;

5.2.1.5 Diagnosis;

5.2.1.6 Treatment given;

5.2.1.7 Condition of the patient on discharge or transfer; and,

5.2.1.8 Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care

5.2.2 Each patient's medical record shall be signed by the member of the Medical Staff in attendance who is responsible for the clinical accuracy

5.2.3 There shall be such review of Emergency Department medical records as the Medical Executive Committee determines to be appropriate for the purposes of evaluating the quality of emergency medical care, and reports shall be submitted to the Medical Staff Quality Management Committee by Emergency Department personnel in such form and at such times as the Medical Staff Quality Management Committee shall determine.

5.3 MASS CASUALTIES

5.3.1 There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.

5.3.2 This plan shall be developed by a Disaster Planning Committee which includes:

5.3.2.1 At least two (2) members of the Medical Staff, one to be a member of the Emergency Department

5.3.2.2 The Chief Nursing Officer or his/her designee

5.3.2.3 A representative from Hospital Administration

5.3.3 The plan shall be approved by the Medical Staff and Governing Body and be appended to this document.

5.3.4 The disaster plan should make provision within the Hospital for:

5.3.4.1 Availability of adequate basic utilities and supplies, including gas, water, food, and essential medical and supportive materials

5.3.4.2 An efficient system of notifying and assigning personnel

5.3.4.3 Unified medical command under the direction of a designated physician (the Chairperson of the Committee or designated substitutes)

5.3.4.4 Conversion of all usable space into clearly defined areas for efficient triage, for patient observation, and for immediate care

5.3.4.5 Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care

5.3.4.6 A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved

5.3.4.7 Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy

5.3.4.8 Maintaining security

5.3.4.9 Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual

5.3.4.9.1 Advance arrangements with communications media will help to provide organized dissemination of information.

5.3.5 Physicians shall be assigned to posts, and it is their responsibility to report to their assigned stations

5.3.6 The Vice President for Medical Affairs/or designee and the President of the Hospital will work as a team to coordinate activities and directions

5.3.7 In cases of evacuation of patients from one section of the Hospital to another or evacuation from the Hospital premises, the Vice President for Medical Affairs/or designee will authorize the movement of patients

5.3.8 All policies concerning direct patient care will be a joint responsibility of the Chiefs of Departments and the President of the Hospital

5.3.9 In their absence, a member of the Department present and the Administrator on call are next in line of authority respectively

5.3.10 The disaster plan should be rehearsed at least twice a year, preferably as a part of a coordinated drill in which other community emergency service agencies participate

5.3.10.1 The drills, which should be realistic, must involve the Medical Staff, as well as Administrative, Nursing, and other Hospital personnel

5.3.10.2 Actual evacuation of patients during drills is optional

5.3.10.3 There should be a written report and evaluation of all drills

5.4 IMMEDIATE CREDENTIALING IN CASE OF MASS DISASTER
***March 2004, August 2006**

In the event of a mass disaster, when the Emergency Management Plan has been activated, Medical Staff members and employees may not be able to provide all the care required by individuals seeking treatment at our facilities. Under such circumstances, the President of the Hospital, Chief of Staff or the Vice President of Medical Affairs/or designee, is authorized to grant emergency privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state or otherwise capable of providing services to patients.

Verification of these individuals is considered a high priority. The Medical Staff Office will begin the verification process on these individuals who receive disaster privileges and will begin as soon as the immediate situation is under control and should be completed within 72 hours unless there are extraordinary circumstances where primary source verification cannot be done. In extraordinary circumstances, the Medical Staff Office will document the following: (1) why primary source verification could not be performed in the required time frame, (2) evidence of a demonstrated ability to continue to provide adequate care, treatment and services, (3) an attempt to rectify the situation as soon as possible. The hospital makes a decision (based on information regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted. This process is identical to the process established under the Medical Staff Bylaws for granting temporary privileges to meet an important patient care need. A permanent record of this information shall be retained by the Medical Staff Office.

5.4.1 If possible, verification of the volunteer's identity by a current medical staff member or hospital employee with personal knowledge regarding practitioner's identity shall be obtained. Also acceptable is a current picture hospital ID card, a current license to practice, a Government-issued photo identification, current photo identification from another hospital and/or identification indicating the individual is a member of a Disaster Medical Assistance Team shall also be obtained, if possible.

5.4.1.1 The practitioner will be paired with a currently credentialed Medical Staff member within their specialty and shall act only under the direct supervision of a Medical Staff member. The practitioner's emergency privileges will be for a period needed for the duration of the disaster as determined by TMC.

5.4.2 Furthermore, notwithstanding any existing delineation privileges or scope of authority, employees and volunteers are authorized to take

whatever steps they reasonable believe are necessary to preserve the life or health of patients or to protect the public health.

Article 6 MEDICAL SCREENING EXAMS AND TRANSFERS

6.1 MEDICAL SCREENING EXAM:

6.1.1 *In Behavioral Health and the Department of Psychiatry,*

6.1.1.1 *Components of the medical screening exam include:*

- 6.1.1.1.1 Presence and severity of homicidal and suicidal ideation
- 6.1.1.1.2 Presence and severity of psychotic thinking and behavior
- 6.1.1.1.3 Ability to care for self
- 6.1.1.1.4 Level of orientation
- 6.1.1.1.5 Judgment and insight

6.1.1.2 *Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols:*

- 6.1.1.2.1 MSW's (Masters of Social Work)
- 6.1.1.2.2 Licensed Professional Counselors
- 6.1.1.2.3 Registered Nurses
- 6.1.1.2.4 Other personnel who must possess one of the following qualifications:
 - 6.1.1.2.4.1 *Batchelor's degree from an accredited school of social work and one year of social work or counseling experience*
 - 6.1.1.2.4.2 *Four year degree in a human service field or related curriculum including at least 15 semester hours in courses related to social work or counseling and two years of social work or counseling experience*
 - 6.1.1.2.4.3 *Graduation from a four-year College or University and three years of experience in rehabilitation counseling, or a related human service field providing experience in the techniques of casework, group work, or community organization.*

6.1.2 *In some circumstances, the individual's condition may warrant another physician's expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the Hospital.*

6.1.3 *In the Emergency Department*

6.1.3.1 *Components of the medical screening exam include:*

- 6.1.3.1.1 History and physical examination;
- 6.1.3.1.2 Appropriate testing;
- 6.1.3.1.3 Completion of appropriate documentation;
- 6.1.3.1.4 Evaluation of the patient, within the capabilities of the Hospital, including the use of indicated on-call physicians as appropriate, to determine whether a patient has an emergency medical condition as defined by law.

6.1.3.2 *Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols:*

- 6.1.3.2.1 Physician's assistants
- 6.1.3.2.2 Advanced practice nurse practitioner
- 6.1.3.2.3 Registered nurses.

6.1.3.3 *In some circumstances, the individual's condition may warrant another physician's expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the Hospital.*

6.1.4 In the Labor and Delivery Departments

6.1.4.1 , **Components of the medical screening exam include:**

6.1.4.1.1 History and physical examination

6.1.4.1.2 Appropriate testing

6.1.4.1.3 Completion of appropriate documentation as per ACOG guidelines

6.1.4.2 *Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols:*

6.1.4.2.1 Labor and Delivery nurses who have passed competencies and course requirements to work in labor and delivery

6.1.4.3 *In some circumstances, the individual's condition may warrant another physician's expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the Hospital.*

6.2 CRITERIA FOR TRANSFER:

***September 2004**

6.2.1 **Definition of TRANSFER:** *the movement (including discharge) of an individual outside a Hospital's facilities at the direction of any Hospital employee or member of the Medical Staff. A transfer does not include such movement of an individual who has been declared dead or who leaves the facility against medical advice or without having been seen.*

6.2.2 **Definition of EMERGENCY MEDICAL CONDITION:** *a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention reasonably could be expected to result in:*

6.2.2.1 *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;*

6.2.2.2 *Serious impairment to bodily functions; or*

6.2.2.3 *Serious dysfunction of any bodily organ or part; or*

6.2.2.4 *With respect to a pregnant woman who is having contractions:*

6.2.2.4.1 That there is inadequate time to effect a safe transfer to another Hospital before delivery
or

6.2.2.4.2 That transfer may pose a threat to the health or safety of the woman or the unborn child.

6.2.2.5 **Definition of dedicated emergency department:** *any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:*

1. It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, or

3. During the calendar year immediately preceding the calendar year for which a determination under this section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

For Novant facilities, including Thomasville Medical Center, "dedicated emergency departments" include emergency departments and labor and delivery departments.

6.2.3 Transfer of Unstable Patients: If a patient has an emergency medical condition that has not been stabilized, the patient may not be transferred unless:

- 6.2.3.1 *The patient needs care that is medically indicated and is not available at the Hospital and the requirements for an appropriate transfer as set forth in Article 6 are met;*

Or

- 6.2.3.2 *The patient (or legally responsible person acting on the patient's behalf) requests the transfer after being informed of the Hospital's obligations under this section and of the risk of transfer.*

- 6.2.3.2.1 The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of transfer;

And

- 6.2.3.3 *A physician or other qualified medical personnel as defined in Article 6 signs a certification of transfer that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, or in the case of a woman in labor, to the woman or the unborn child, from being transferred.*

- 6.2.3.3.1 The certification must contain a summary of the risks and benefits upon which it is based.

6.2.4 APPROPRIATE TRANSFER: a transfer from a dedicated emergency department to another medical facility will be appropriate only in those cases in which:

- 6.2.4.1 *The transferring Hospital provided medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.*

- 6.2.4.2 *The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment; and*

- 6.2.4.3 *The transferring Hospital sends to the receiving facility copies of all medical records related to the emergency condition which are available at the time of the transfer and the informed written consent or certification and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.*

- 6.2.4.3.1 Other records not available at the time of transfer must be sent as soon as practicable.

6.2.5 Definition of STABILIZED: with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from the facility, or in the case of a woman in labor, that the woman has delivered the child and the placenta.

- 6.2.5.1 *A patient will be deemed stabilized if the treating physician has determined that the emergency medical condition is deemed not to present a threat to the patient during the time of transfer of the patient.*

6.2.6 CERTIFICATION FOR TRANSFER: *When a physician is not physically present, the following categories of individuals are designated as qualified medical personnel who*

6.2.6.1 *Are authorized to consult by telephone with a physician to determine whether the medical benefits of transferring an individual outweigh the increased risks of transfer,*

6.2.6.2 *Are authorized to sign the certification for transfer form after the physician has made the determination to transfer, subject to established protocols and the physician's subsequent countersignature of the certification form:*

6.2.6.2.1 Behavioral Health –

6.2.6.2.1.1 *MSWs (Masters of Social Work);*

6.2.6.2.1.2 *Licensed Professional Counselors,*

6.2.6.2.1.3 *Registered Nurses*

6.2.6.2.1.4 *Others as defined in Article 6.1.1.2.4*

6.2.6.2.2 Emergency Department

6.2.6.2.2.1 *Physician Assistants*

6.2.6.2.2.2 *Advance Practice Nurse Practitioners*

6.2.6.2.3 Labor and Delivery

6.2.6.2.3.1 *Labor and Delivery nurses who have passed all competencies and course requirements to work in labor and delivery*

6.2.6.2.3.2 *Neonatal nurse practitioners are designated as qualified medical personnel who are authorized to transfer newborns.*

Article 7 MEDICAL STAFF APPOINTMENTS TO THE BOARD OF DIRECTORS

7.1 There will be five (5) physicians on the Board of Directors of Community General Hospital.

7.1.1 The Past Chief of Staff

7.1.2 The Present Chief of Staff

7.1.3 The Chief of Staff Elect

7.1.4 An At Large Member of the Medical Staff

7.1.5 An At Large Member of the Medical Staff

7.2 All Members of the Medical Staff will be eligible for election, limited only by their own choice of Medical Staff category.

7.2.1 Members of the Active Staff only will be eligible for election to the Board of Directors.

7.3 The Medical Staff as a whole will elect all Medical Staff members of the Board of Directors.

7.3.1 The Past Chief of Staff, Chief of Staff, and the Chief of Staff Elect will be elected by the Medical Staff as described in the Medical Staff Bylaws

7.3.2 The terms of the At Large members will be staggered so that elections will occur during two out of every three years.

7.3.3 The Medical Staff 's At Large Members of the Board of Directors will be elected at the Annual meeting of the Medical Staff by the following process:

7.3.3.1 At the annual meeting of the Medical Staff, the Medical Staff as a whole will serve as an Ad Hoc Nominating Committee.

7.3.3.2 Each member present will be entitled to select three (3) eligible members of the Medical Staff for the position of At Large Member of the Board of Directors.

7.3.3.2.1 Proxy votes will not be accepted.

7.3.3.2.2 Absentee ballots will be accepted on written request to the Chief of Staff within five (5) weekdays of the meeting and will be due back within seven (7) weekdays of the meeting.

7.3.3.3 The Nominating Committee of the Medical Staff will tabulate the ballots.

7.3.3.4 The Nominating Committee of the Medical Staff will list the nominees in order of votes received with the member with the highest number of votes on the top of the list.

7.3.3.5 The Nominating Committee will offer the position of At Large Member of the Board of Directors to the Medical Staff Member at the top of the list.

7.3.3.5.1 If the Medical Staff Member at the top of the list declines to serve, the Nominating Committee will offer the position to the Medical Staff Member with the next highest number of

votes, and continue in this fashion until either a Medical Staff Member accepts the position or the list is exhausted.

7.3.3.5.2 If the list is exhausted, the Nominating Committee may offer the position to Members of the Medical Staff who did not receive any votes.

7.4 The term of office will be for three years, and will run from January to January.

7.5 If a Member of the Medical Staff is unable to serve the entire three-year term, then a substitute will be elected to serve the remaining time of that three-year term.

7.5.1 The Substitute Member of the Medical Staff will be elected according to the procedure described above Article 7.3.3

7.5.2 The election will occur at the next regularly scheduled or emergency meeting of the Medical Staff.

7.5.3 If a vacancy arises on the Board by an At Large member of the Medical Staff and is subsequently filled per the process in Article 7.5 then the Medical Staff can vote at a regular Medical Staff meeting to allow the person to serve a 3-year term on the Board in addition to completing the remainder of the term to whom they were elected.

7.5.3.1 This vote would just require a majority of members present at the meeting.

7.5.3.2 No proxy or absentee votes will be accepted.

Article 8 PHYSICIANS HEALTH AND EFFECTIVENESS POLICY (PHEP)

8.1 PURPOSE:

8.1.1 *The Medical Staff of the Thomasville Medical Center is charged with the responsibility of overseeing and maintaining quality patient care*

8.1.2 *It is the responsibility of each member of the medical and Hospital staff to report observations characteristic of one or more of the problems described below*

8.1.3 *This report may be made through the Chief of Staff, department chief, an administrative officer, or the Medical Staff Office, but must be documented on the Observation Report (Attachment A)*

8.1.4 *The Medical Staff Office is available to assist with the report*

8.1.5 *To fulfill the Medical Staff and Hospital's primary responsibility to the patient, the Medical Staff is hereby committed to identifying and providing counseling for impaired and disruptive physicians, oral surgeons, or podiatrists on the Medical Staff by:*

8.1.5.1 *Endorsing the principles of the North Carolina Physicians Health Program (NCPHP) (Attachment B);*

8.1.5.2 *Working in concert with the state program*

8.1.5.3 *Developing a role of advocacy within this policy by providing a mechanism for:*

8.1.5.3.1 Identification of problems

8.1.5.3.2 A process for fair assessment of potential problems

8.1.5.3.3 Assistance rather than discipline in dealing with problems

8.1.5.3.4 Maintaining and assuring confidentiality

8.2 MECHANISM FOR IDENTIFICATION AND FAIR ASSESSMENT OF OCCURRENCES:

8.2.1 *The following steps should be followed when a potential problem involving a member of the Medical Staff is observed:*

8.2.1.1 *An observation report (Attachment A) should be completed for occurrences attributable to a physician, oral surgeon, or podiatrist involving questionable professional conduct or technical competence*

8.2.1.2 *Any physician, oral surgeon, podiatrist, employee, patient, or visitor may report the questionable occurrence.*

8.2.1.3 *Reportable occurrences could include, but are not limited to the following:*

8.2.1.3.1 Verbal or physical abuse, including attacks leveled at other members of the Medical Staff or allied health personnel, Hospital personnel, or patients, that are personal, irrelevant, or beyond the bounds of fair professional conduct

8.2.1.3.2 Impertinent and/or inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care in the Hospital, or attacking particular member of the Medical Staff or allied health personnel, nurses, or Hospital policies

- 8.2.1.3.3 Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence
- 8.2.1.3.4 Episode involving possible sexual harassment
- 8.2.1.3.5 Failure to respond in a timely manner to pages or calls
- 8.2.1.3.6 Episode of questionable technical competence

8.2.1.4 *The completed observation report should be forwarded to the Medical Staff Office and should include:*

- 8.2.1.4.1 The date and time of the questionable conduct
- 8.2.1.4.2 A statement of whether the behavior affected or involved a patient in any way, and, if so, the name of the patient
- 8.2.1.4.3 The circumstances that precipitated the situation
- 8.2.1.4.4 A description of the questionable behavior that is limited to factual, objective language
- 8.2.1.4.5 The consequences, if any, of the disruptive behavior as it relates to patient care or Hospital operations
- 8.2.1.4.6 A record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening

8.2.1.5 *All reports involving questions of technical competence will be referred to the Medical Staff Quality Management Committee*

8.2.1.6 *Reports involving disruptive or unprofessional behavior will be initially investigated by the Vice President of Medical Affairs/or designee under the direction of the Chief of Staff in consultation with the Department Chief for the physician, oral surgeon, or podiatrist about whom the report was submitted*

- 8.2.1.6.1 The member of the Medical Staff will be informed that the report has been submitted and will be given the opportunity to respond either verbally or in writing to the allegations contained in the report prior to any further determination being made regarding the validity of the allegations or actions to be considered

8.2.1.7 *Following initial investigation, the Chief of the Medical Staff and the Vice President of Medical Affairs/or designee shall make one of the following determinations:*

- 8.2.1.7.1 That the report is apparently frivolous.
 - 8.2.1.7.1.1 *In this event, no action will be taken and the report will be kept in the member of the Medical Staff's credentials file for the balance of the current and subsequent appointment period.*
 - 8.2.1.7.1.2 *The report will be destroyed at the end of the subsequent appointment period unless another similar occurrence is reported.*
- 8.2.1.7.2 That the report is founded.
 - 8.2.1.7.2.1 *Depending upon the severity of the occurrence, the following options are available to address the issue(s) raised:*
 - 8.2.1.7.2.1.1 A single confirmed occurrence warrants a discussion with the member of the Medical Staff; the Vice President for Medical Affairs under the direction of the Chief of Staff shall initiate such discussion, which may involve the appropriate Department Chief, and emphasize that such conduct which gave rise to the report is inappropriate and must cease. The initial approach should be collegial and helpful to the physician and the Hospital. Documentation of the occurrence and the physician's written and/or verbal response as well as documentation of the discussion will be provided to the member of the Medical Staff and retained in the member of the Medical Staff's Peer Review file.
 - 8.2.1.7.2.1.2 A confirmed occurrence which appears to describe a situation when failure to take immediate action would result in imminent danger to the health and/or safety of any individual or to the orderly operations of the Hospital should be dealt with as outlined in the Bylaws of the Medical Staff or applicable Medical Staff policies, rules or regulations.

8.2.1.8 *A second confirmed occurrence will, at the discretion of the Chief of Staff, be referred to the MSQM Committee for review as outlined below.*

8.3 TMC PHYSICIANS HEALTH AND EFFECTIVENESS COMMITTEE:

8.3.1 There shall be a standing ad hoc Medical Staff committee for physician health and effectiveness (PHEC) whose composition and function shall be as follows:

8.3.1.1 Composition:

8.3.1.1.1 Three (3) to five (5) Medical Staff members, plus a designated Administrative officer

8.3.1.1.2 Chairperson and members to be selected by the Chief of Staff with the concurrence of Hospital administration

8.3.1.2 Function:

8.3.1.2.1 Support the approved PHP Policy

8.3.1.2.2 Perform in an advocacy/advisory role in identifying the impaired or disruptive member of the Medical Staff

8.3.1.2.3 Support the North Carolina PHP by referral of impaired or disruptive members of the Medical Staff once appropriate steps have been taken at the Hospital level

8.3.1.2.4 Provide on site intervention, support, counsel, and follow-up on acute episodes by an impaired or disruptive member of the Medical Staff

8.3.1.2.5 Provide support, counsel and follow-up on appropriately reported insidious/chronic episodes by an impaired or disruptive member of the Medical Staff

8.3.1.2.6 Meet on an as needed basis to review specific complaints to determine appropriate action

8.3.1.2.7 Meet on an as needed basis to act in an advocacy/counseling role for any member of the Medical Staff upon request

8.3.1.2.8 Develop re-entry and follow-up protocols for impaired or disruptive members of the Medical Staff.

8.3.1.3 Criteria for Initiation of Physicians Health and Effectiveness Committee Action:

8.3.1.3.1 Investigation and/or intervention by the Physicians Health and Effectiveness Committee shall be initiated on two (2) documented occurrences as outlined above

8.3.1.3.2 If it appears to the Committee that a pattern of documented disruptive behavior is developing, the Committee shall ask that the member of the Medical Staff involved meet with the Committee and shall discuss the matter with the member of the Medical Staff as follows:

8.3.1.3.2.1 *Emphasize that if such repeated behavior continues, more formal action will be taken to stop it and that in this event, the Medical Staff Quality Management Committee investigative procedure as outlined in the Bylaws, Rules and Regulations, or Policies of the Medical Staff*

8.3.1.3.2.2 *A follow-up letter to the member of the Medical Staff sent by certified mail/return receipt requested shall state the nature of the problem and inform the member of the Medical Staff that he or she is required to behave professionally and cooperatively within the Hospital.*

8.3.1.3.2.1 Follow-up action may also include the establishment of a contract with the member of the Medical Staff outlining his/her ongoing responsibilities for improving and maintaining professional behavior and for monitoring his/her progress in achieving compliance.

8.3.1.3.2.3 *All meetings will be documented and included in the member of the Medical Staff's Peer Review File.*

8.3.1.3.3 While no one policy will be suitable in every circumstance, two confirmed occurrences involving impairment, which may include a variety of problems, from age to substance abuse to physical or mental illness, will be addressed as the circumstances dictate, but in all cases the risk of patient harm must be of paramount concern and immediate action may be required as outlined in the Bylaws, Rules and Regulations, or Policies of the Medical Staff

8.3.1.3.4 Determination of impairment may be confirmed as the result of an investigation that may be conducted by the Committee or any resource available to the Committee, including, but not limited to the Medical Staff Quality Management Committee, an outside consultant, or another individual(s) appropriate under the circumstances

8.3.1.3.4.1 *If the investigation produces sufficient evidence that the member of the Medical Staff is impaired, the Committee or other designated persons shall meet personally with that member of the Medical Staff for the purpose of referring the member of the Medical Staff to*

the North Carolina Physicians Health Program (NCPHP) for formal evaluation and development of a plan of care

8.3.1.3.5 Either the Committee or the involved member of the Medical Staff may determine that referral to the NCPHP is not the appropriate option for intervention

8.3.1.3.5.1 *In this event, the Committee shall provide the member of the Medical Staff a list of local, state and national approved counseling/rehabilitation programs from which the member of the Medical Staff may select for formal evaluation and development of plan of care*

8.3.1.3.6 In the event that the member of the Medical Staff does not voluntarily agree to be referred to the North Carolina Physicians Health Program or the alternative suggested in Article 8.3.1.3.5 above, the Committee may recommend to the Medical Staff Quality Management Committee that the individual's clinical privileges be suspended and report the individual to the North Carolina Physicians Health Program for review and appropriate action

8.3.1.3.7 If patient care continuity is in question, a PHEC physician, with the concurrence of the Department Chief or Chief Staff, may contact an alternate member of the Medical Staff to assure that appropriate care is provided in place of the member of the Medical Staff under investigation.

8.3.1.4 Monitoring and Follow-up

8.3.1.4.1 Upon sufficient proof that a member of the Medical Staff who has been found to be suffering an impairment has successfully completed a rehabilitation program, the Committee may consider recommending reinstatement of that individual to the Medical Staff

8.3.1.4.2 When considering an impaired member of the Medical Staff for reinstatement, the Committee must consider patient care interests to be paramount

8.3.1.4.3 The Committee must first obtain a letter from the physician director of the rehabilitation program where the individual was treated and/or from the North Carolina Physicians Health Program if appropriate. The individual must authorize the release of this information. The letter from the director of the rehabilitation program and/or the NCPHP shall state:

8.3.1.4.3.1 *Whether the member of the Medical Staff is participating in the program*

8.3.1.4.3.2 *Whether the member of the Medical Staff is in compliance with all of the terms of the program*

8.3.1.4.3.3 *Whether the member of the Medical Staff attends program meetings regularly (if appropriate)*

8.3.1.4.3.4 *To what extent the member of the Medical Staff's behavior and conduct are monitored*

8.3.1.4.3.5 *Whether, in the opinion of the rehabilitation program physicians, the member of the Medical Staff is rehabilitated*

8.3.1.4.3.6 *Whether an after-care program has been recommended to the member of the Medical Staff and, if so, a description of the after-care program*

8.3.1.4.3.7 *Whether, in the program director's and/or the NCPHP director's opinion, the member of the Medical Staff is capable of resuming medical practice and providing continuous, competent care to patients.*

8.3.1.4.4 The member of the Medical Staff must inform the Committee of the name and address of his or her primary care physician, and must authorize the physician to provide the Committee with information regarding his or her condition and treatment.

8.3.1.4.4.1 *The Committee has the right to require an opinion from other physician consultants of its choice.*

8.3.1.4.5 The Committee shall request the primary care physician to provide information regarding the precise nature of the member of the Medical Staff's condition, the course of treatment, and the answers to the questions posed above in Articles 8.3.1.4.3.5 and Article 8.3.1.4.3.7

8.3.1.4.6 Assuming all information the Committee receives indicates that the member of the Medical Staff is rehabilitated and capable of resuming patient care, the Committee must take the following additional precautions before recommending that clinical privileges be restored:

8.3.1.4.6.1 *The member of the Medical Staff must identify two physicians who are willing to assume responsibility for the care of his or her patients in the event that he or she is unable or unavailable to care for them*

8.3.1.4.6.2 *The Committee shall require the member of the Medical Staff provide the Committee with periodic reports from his or her primary care physician, from the NCPHP, if appropriate, and from any after care programs in which the member of the Medical Staff participates, for a period of time specified by the Committee, stating that the physician is continuing treatment*

or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.

- 8.3.1.4.7 The Department Chief or a physician appointed by the Committee in consultation with the Department Chief shall monitor the member of the Medical Staff's exercise of clinical privileges in the Hospital. The Committee shall determine the nature of that monitoring after reviewing all of the circumstances.
- 8.3.1.4.8 The member of the Medical Staff must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of a member of the Committee, Hospital management, or Medical Staff Quality Management Committee if it is suspected that he/she may be under the influence of drugs or alcohol.
- 8.3.1.4.9 All requests for information concerning the impaired member of the Medical Staff shall be forwarded to the Vice President for Medical Affairs/or designee for response.

8.4 CONFIDENTIALITY

8.4.1 Actions taken and recommendations made pursuant to this Policy shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board of Directors.

- 8.4.1.1 *In addition, reports of actions taken pursuant to this policy shall be made by the President of the Hospital to such governmental agencies as may be required by law.*

8.4.2 All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by the provisions of NC General Statutes 90-14.13, 131E-87 or 131E-95 or the corresponding provisions of any other Federal or State statute providing protection to peer review or related activities. Furthermore, the Committee and/or person(s) charged with making reports, findings, recommendations, or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and its Board of Directors when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" and/or "medical review committees" as those terms are defined in the Health Care Quality Improvement Act of 1986 and/or North Carolina State Statutes.

8.5 RIGHTS OF MEDICAL STAFF MEMBERS

- 8.5.1 To be informed of any and all reports submitted regarding his/her professional conduct and/or technical competence.***
- 8.5.2 To be allowed to submit a written and/or verbal response to any reports submitted regarding his/her professional conduct and/or technical competence.***
- 8.5.3 To be allowed to provide additional information and/or reports from other persons that may support other interpretations of the event(s) that led to a report being submitted regarding his/her professional conduct and/or technical competence.***
- 8.5.4 To receive copies of any reports or other written material which will be included in his/her peer review file.***

- 8.5.5** *To have all reports and/or other documentation which are determined to be apparently frivolous handled as per Article 8.2.1.7.1 of the PHEP Policy.*
- 8.5.6** *To have all reports and/or other documentation regarding his/her professional behavior and/or technical competence treated with the highest regard for confidentiality.*

**ATTACHMENT A
CONFIDENTIAL OBSERVATION REPORT
INVOLVING MEDICAL STAFF**

DATE: _____ TIME: _____

MEMBER OF MEDICAL STAFF INVOLVED IN EPISODE: _____

LOCATION OF OCCURRENCE: _____

I. DESCRIPTION OF OCCURRENCE: (Circle a number from the following definition that best describes the episode.)

- (1) Questionable professional conduct:
 - a) Verbal or physical abuse.
 - b) Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents
 - c) Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence
 - d) Episode involving possible sexual harassment
 - e) Failure to respond in a timely manner to pages or calls
 - f) Other (Specify)
- (2) Questionable technical competence

II. BRIEF DESCRIPTION OF OBSERVED EPISODE:

SIGNATURE of OBSERVER: _____

The following signature must be present if the observer is not a physician:

SUPERVISOR'S SIGNATURE: _____ TITLE _____

Signature(s) must be present for the episode to be addressed.

Return this form to the Medical Staff Office

All observations will be reviewed as outlined in the Physicians' Health and Effectiveness Policy and handled confidentially.

ATTACHMENT B

NORTH CAROLINA PHYSICIANS HEALTH PROGRAM GOAL

To identify all impaired physicians in the State of North Carolina, to assist them in preserving their health, and to help them return to treating patients in the most effective manner or to help them move into their chosen alternative.

PROGRAM PRINCIPLES

1. That humanitarian concern for the public and impaired physicians motivates the program.
2. That alcoholism, drug abuse, and mental illness are treatable conditions.
3. That alcoholism, drug abuse, and mental illness among physicians should not be ignored or left untreated.
4. Those impaired physicians are obliged to seek help and cooperate in treatment in order to regain or retain their full effectiveness to practice medicine.
5. That impairment may be established by a physician's acknowledgment or admission or by the observance and evaluation of peers knowledgeable about these conditions.
6. *That it is every physician's responsibility to be cognizant of any colleague's chemical dependency and/or mental illness and to assist these colleagues in receiving appropriate treatment.*
7. Those impaired physicians who refuse to cooperate with the Program must be reported immediately to the Medical Board of the State of North Carolina.

**Article 9 ORGANIZED HEALTH CARE ARRANGEMENT
(OHCA)**

All individuals holding medical staff appointment and/or clinical privileges at Thomasville Medical Center and applicants for the same shall, as a condition of their appointment, be required to participate in an Organized Health Care Arrangement (OHCA) for purposes of complying with the HIPAA privacy regulations. By participating in the OHCA, the members of the Medical Staff agree to follow the Novant Health Joint Notice of Privacy Practices while practicing in a Novant facility. Further, members of the Medical Staff agree to follow related Novant Health policies that govern the use and disclosure of Protected Health Information (PHI) with regard to any PHI received as part of his or her membership on the Medical Staff. Novant Health shall be responsible for providing patients with a copy of the Joint Notice of Privacy Practice and obtaining a signed acknowledgement from the patient or representative indicating that he or she received a copy of the Notice. In the event that the Joint Notice of Privacy Practices is amended, Novant Health shall provide an updated version to the Medical staff Executive Committee and, if necessary, to the entire Medical Staff.

Article 10 Standing Orders

***December 2003**

10.1 INR will be done every 3 days on patients receiving Coumadin.

10.2 No MD order will be needed for influenza and pneumonia vaccinations

/