Saint Francis Healthcare

Medical Staff
Rules and Regulations

Revised:

July 24, 2012
October 28, 2014
January 29, 2018

RULES AND REGULATIONS
Table of Contents

MEDICAL STAFF RULES AND REGULATIONS

A. RIGHTS OF PATIENT AND ORGANIZATIONAL ETHICS

1. An invasive procedure or transfusion of blood products shall be performed only with the consent of the patient or his/her legal representative, except in an emergency.

2. Physicians admitting private patients shall be held responsible for giving such information as may seem necessary to assure the protection of other patients and personnel from those patients who are a source of danger from any cause whatsoever, or to assure the protection of the patient from self-harm.

3. All patients noted to have attempted suicide as a reason for admission to the hospital or during hospitalization or who are identified as having illness of an emotional nature or related to substance abuse should be offered psychiatric consultation and treatment as soon as they are well enough physically to make an evaluation possible. Such offer shall be documented on the medical record with the response of the patient.

B. ASSESSMENT OF PATIENTS

1. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after the admission as possible.

2. An adequate and appropriate history and physical shall in all cases be documented within twenty-four (24) hours after admission of the patient. The Patient receives a medical history and physical examination no more-than 30 days prior to, or within 24 hours after, registration or inpatient admissions, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia." The physician must document that: "I have re-examined reassessed the patient and there are no significant changes." Including the date, time and signature. A history and physical should have the medical history with chief complaint, the details of present illness, past medical history, relevant social history, family history, review of systems, and physical exam. Also required would be the practitioner's conclusion, impressions, and plan of action for this episode of care. These examinations must be dictated through the central dictating system or completed through the EMR charting system. If dictated, a signed electronic note giving the assessment and plan must be done in the electronic medical record. In the case of a patient going to surgery, except for emergency procedures, the transcribed copy of a dictated history and physical or an electronically generated history and physical performed by a member of the Medical Staff must be on the chart prior to the surgery. The history must contain at least the following: indications/symptoms for the surgical procedure, a list of current medications and their dosages, any known allergies and drug reactions, and any co-morbid conditions. Documentation of the physician exam must include a heart and lung exam and an evaluation of the general condition and mental status of the patient. The preoperative diagnosis must be recorded in the chart prior to surgery. History and physicals performed by Allied Health Professionals, who have privileges to perform a history and physical, do not require countersignature by a supervising physician.

3. Patients admitted for dental or podiatric procedures shall be admitted on the Dentist's or Podiatrist's service. Each patient must have an adequate history and physical by a member of the Medical Staff

of Saint Francis Healthcare or qualified Allied Health Professional, or in the case of podiatric procedure, the podiatrist. Appropriate consultation shall be held in complicated cases. The Dentist is responsible for the patient's history related to the indications/symptoms for the dental procedure only.

4. Appropriate action shall be taken to rule out pregnancy in any procedure, operation, etc. which could interrupt a known, or suspected pregnancy. Such action shall be documented in the medical record.

5. For Non-Inpatient services, patient assessment requirements will be fulfilled as follows:

Anesthetic Characterization:	Categories and Examples:	Documentation Requirements:
None to Minimal Anesthesia Services:	♦ Phlebotomy ♦ Transfusions ♦ Diagnostic Imaging with Contrast Dye ♦ Non-OR procedures e.g. skin lesion removal, foley insertion	• None • Allergies; Indications for blood products • Allergies; Risk factors for contrast reaction; Reason for examination • Allergies; Indications for procedure
Moderate Sedation/Analgesia Services:	♦ GI Endoscopies ♦ Angiographic/ Interventions (e.g. peripheral artery stenting, vascular access procedures, biopsies) ♦ Cardiac Catheterizations ♦ Bronchoscopies ♦ Emergency Department Treatments All other moderate sedation services.	• Completion of Outpatient H & P Form or equivalent, or Emergency Department Patient Assessment Form, or Equivalent Inpatient documentation
Deep Sedation/Analgesia and Anesthesia:	♦ OR Procedures	• Completion of Outpatient H & P Form or equivalent, or Equivalent Inpatient documentation

Documentation requirements must be fulfilled prior to the initiation of the procedures or treatments.

The extent of the patient's assessment should equate with the anesthetic risk and potential for complication for the intended procedure. As risks for anesthesia and complications rise, so should the appropriate documentation allowing for proper evaluation and decision-making at critical times for the patient. Since the potential for inpatient admission increases as well, these documentation requirements allow for initial comparison of key parameters and initiation of treatments. Meanwhile, lengthier inpatient assessments can be performed by the attending clinicians.

The Outpatient Form contains: 1) a medical history including present illness and chief complaint, relevant past medical and surgical history, medications, allergies and drug reactions, and a relevant social history, family history, and review of systems; 2) the physical exam that is relevant to the procedure and must include general condition, heart, lung, and mental status of the patient; 3) an assessment noting conclusions and impressions, and 4) a plan of treatment.

C. TREATMENT OF PATIENTS

1. Prescribing Drugs: As far as possible, only drugs in the hospital formulary shall be prescribed. Occasionally, a non-formulary product may be requested when no therapeutic equivalent formulary product exists, or formulary medications have been used and proven unsuccessful in a specific patient. A non-formulary drug will be obtained upon receipt of the Request of Non-Formulary Drug Form, completed by the physician for each patient. Assent to the use of a Formulary system shall be implied by the acceptance of privileges and the agreement to abide by the Bylaws, Rules and Regulations of the Medical Staff.

2. Renewal of Prescriptions: A request for the inclusion of a drug or preparation to the formulary shall be made by submitting a Formulary Addition Request Form to the Director of Pharmacy. This form is available from the Pharmacy upon request of Medical Staff members. Each application shall be reviewed by the Medication Use Committee with whatever consultation may be deemed necessary. (AS PER SFH FORMULARY)

   Specific medications must be renewed on a regular basis during the patient's stay in the hospital.

   a. These specific medications include: (AS PER SFH FORMULARY)

Anticoagulants	Renew every 24 hours (except for "mini-dose" heparin regimens that do not result in changes in whole blood PTT/PT. Doses such as 5,000 units, every 12 hours (subcutaneously)
Antibiotics	Renew every 7 days unless ordered by a physician for a specific length of time
Narcotics & barbiturates	Renew every 72 hours unless ordered by a sedatives & hypnotics for a specific length of time.
All other medications	Renew every 30 days
Primary IV solutions	Renew every 30 days

   b. Intermittent positive breathing, Aerosol Therapy and Incentive Spirometry which are ordered without time limitation shall be automatically discontinued at 72 hours.

c. The attending physician must be notified of the discontinuance of the drugs and procedures noted.

3. Oxytoxic Drugs: Oxytoxic drugs will be administered to undelivered patients under such regulations promulgated by the Chairman of the Department of Obstetrics after proper consultation with the other members of the department.

4. Experimental and Investigative Procedures and Drugs: All new, experimental and investigative procedures and drugs must be approved by the Saint Francis Healthcare IRB Committee (Institutional Review Committee) prior to implementation. A complete protocol for such procedures or drugs must be submitted through the appropriate Departmental Chairman to the VPMA/CMO.

This rule applies equally to investigative drugs, i.e., drugs that had been developed for one purpose, available for medical use that several months or years later are used for a completely different purpose.

Such medications and drugs are investigational during the appropriate transition. Therefore, if a member of the staff has knowledge that the use of a medication or drug is investigational and he/she wishes to use it for its investigational purpose, he/she must inform the patient of the investigational aspect and make known on a detailed progress note this fact. On the Order Sheet he/she would request that the VPMA/CMO be notified in order to obtain the appropriate consent for permission for investigational drugs. The physician is responsible for obtaining an informed consent from the patient.

All papers to be submitted for publication utilizing information from Saint Francis Healthcare or any reference including a bibliography or biography in which Saint Francis Healthcare will be identified, must be reviewed and approved for publication by the IRB Committee.

The Committee will also provide these same functions for all components of Saint Francis Healthcare, as well as its Medical Staff.

5. Standing Orders: A physician wishing to establish standing orders shall submit them to the Chairperson for the Department in which he/she is a member. Upon approval by the MEC, the Standing Orders will be implemented. The nursing leader shall notify all personnel concerned. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician, they shall constitute the orders for treatment. Standing Orders shall not, however, replace or cancel those orders written for a specific patient.

6. Pre-printed Orders: Pre-printed orders may be submitted by a physician. Such pre-printed orders should be submitted to the Vice President of Patient Services for implementation. Each physician shall be requested to review such pre-printed orders once every two years.

7. Use of Restraints: The use of restraints requires a physician's order. The order shall include:

   a. The reason for restraint,

   b. Type of restraint to be used,

   c. Time limitation not to exceed 24 hours,

d. Written orders for restraint/seclusion are limited to:

- Twenty-four (24) hours;
- Four (4) hours for adults with primary behavioral health needs;
- Two (2) hours for children and adolescents, ages 9-17 with primary behavioral health needs; or
- One (1) hour for patients under the age of nine (9) with primary behavioral health needs.

D. OPERATIVE AND OTHER INVASIVE PROCEDURES

1. Preoperative Testing

a. Patients scheduled for surgery should be encouraged to utilize the preadmission testing program at Saint Francis Healthcare. Such patients should report to the Central Registration Desk at least two days and not more than thirty (30) days prior to their scheduled surgery for the pre-operative tests outline below with a written order from the attending physician at the same time.

b. For all patients for whom the service of a member of the Department of Anesthesiology is required, the following minimum laboratory work shall be completed, recorded and available to the anesthesiologist prior to performance of the procedure for which the anesthesia is required. Laboratory studies may be obtained at any licensed laboratory within thirty (30) days prior to hospitalization except as noted below.

c. Variations in this rule are permitted by the application of appropriate clinical judgment or at such time as meeting these requirements would be detrimental to patient care, such as the time delay when definitive action should occur immediately. All variations or exceptions must be written on the Physician's Order Sheet and the reason documented in the Progress Notes.

d. Any suggestion of any change in the patient's condition, as noted by the anesthesiologist or attending physician, may warrant re-evaluation the day of the procedure with additional or verification testing.

e. Medical, Surgical Gynecological, Dental Patients and Pediatric Patients

- CBC
- Potassium (for all patients on diuretics or cardiac medications)
- Glucose (the day of surgery for insulin dependent diabetics)
- Chem 7 Profile (for all patients with major organ system disease)

f. EKG will be required after the age of 45 years for men and 50 years for women.

EKG within six months for patients without history of cardiovascular disease.
EKG within one month for patients with history of cardiovascular disease.

g. For such patients who are on anticoagulants: the PT, PTT and platelet count should be obtained within 4 hours of the procedure. For interventional procedures in addition to the above, a complete Blood Count (CBC) should be obtained within 1-2 days of the procedure unless recent blood loss indicates a shorter interval.

h. Patients not anti-coagulated, but who are to have angiography or other such radiological interventional procedures: A platelet count, PT, and PTT within one week of the procedure. In patients over 40 years of age or diabetic patients or those with multiple myeloma: a BUN.

i. For all C-Section patients: Routine Type and Screen

j. A patient who is in the hospital for more than 96 hours and who is subsequently scheduled for any procedure under general or regional anesthesia must have a CBC performed and recorded on his/her chart within 48 hours prior to the procedure. If a series of Electroshock Therapy (EST) is planned, this requirement must be fulfilled before the first treatment is given but not before each treatment.

k. Patients scheduled for tonsillectomy and/or adenoidectomy: At the Discretion of the Attending Otolaryngologist specific orders must be written for patients to have performed:

- Bleeding time
- Prothrombin time
- Activated Plasma Partial Thromboplastin Time

2. **Preoperative Assessment**

a. An adequate and appropriate history and physical examination (H&P) is required on the chart before operation. Under emergency situations each person will be assessed on an individual basis.

In non-emergent situations an H&P must be on the chart and been performed within 30 days prior to admission (inpatient or outpatient). If the H&P was performed more than 24 hours prior to admission, the H&P must be updated by a qualified physician or allied health professional with clinical privileges to perform a history and physical prior to surgery within 24 hours of admission noting any change of status for the patient, updating any relevant studies, and documenting the continued need for the procedure or admission and validity of the H&P.

b. A pre-anesthesia consultation shall be performed, including a review of the medical history and physical examination within 48 hours prior to the operation by the Anesthesiologist or the physician in charge of the anesthesia. An anesthesia record shall be completed for each patient receiving general or regional anesthesia and a post-anesthesia note shall be recorded for each patient concerning the general condition of the patient. A pre-induction assessment will be performed prior to administration of anesthesia.

3. **Specimen/Tissue Removal**

Operative material and tissue for examination will follow these rules:

"All material of any type that is removed from the patient should be recorded. Tissue may be sent for regular histologic examination or with a request for gross examination and description only with the understanding that the pathologist will go further with histologic examination if he/she feels it is necessary";

"Exceptions to sending specimens removed during a surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely employed and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include the following:

a. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, portion of rib removed only to enhance operative exposure, scars, and normal tissue removed in cosmetic surgery.

b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

c. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.

d. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

e. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin for the circumcision of a newborn infant.

f. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

g. Teeth, provided the number, including fragments, is recorded in the medical record.

E. COORDINATION OF CARE

1. Physician Responsibility to Patient: The admitting physicians or his/her qualified substitute will visit his/her hospital patients daily while in any section of the acute care departments of the hospital. This rule is in order to provide adequate quality, cost-effective care along with adequate communication with the patient, family and other staff members. The physician, or his/her qualified substitute, must be constantly available to care for patient problems. Failure of a physician to make daily visits to his/her patients will be reviewed by the Department Chairperson and may result in curtailment of the physician's privileges. All visits should be appropriately documented on the chart on the date of the visit and provide a meaningful description of the status of the patient as of that time.

2. Substitute Physician: Each member of the Medical Staff shall name another member of the Medical Staff who may be called in his/her absence or when he/she is not available to attend his/her patients. Such substitute physician must hold at least the same privileges and have at least the same delineation of privileges. In the event of failure to name such a substitute (or of the named substitute to respond), the Chief Executive Officer of the hospital and the Chairperson of the Department involved, shall have the authority to call any member of the staff to attend the patient in the emergency situation.

3. Consultations: When an attending physician requests consultation, he/she must specify on the appropriate form his/her expectation from the consultation. He/she will ensure, except in an emergency, that an appropriate and adequate history and physician examination is recorded on the chart. The attending physician remains responsible for the patient and will be queried as to any questions concerning the activity of the consultant.

4. Transfer of Responsibility: The transfer of responsibility from one physician to another physician, whether interdepartmental or within the same Department shall be by order of the attending physician. The performance of major surgery shall of itself constitute a de facto transfer to that surgical service (physician) unless otherwise ordered by the surgical physician. Major surgery includes that surgery on inpatients requiring a general or a spinal anesthetic. It is understood that ALL pre-operative orders cease at the time of major surgery and must be rewritten post-operatively.

   When a patient is transferred from one physician's care to another, the transferring physician shall write a progress note summarizing the patient's record up to that time so this information can easily be incorporated later into the Discharge Summary. A transfer of a patient will require a written order for the transfer. The current attending Staff Member shall provide care of the patient until the transfer has been fully completed.

5. Service Patients: All service patients shall be attended by members of the Active Staff, Associate Staff and shall be assigned to the service concerned with the treatment of the disease which necessitated admission. Those physicians shall attend the patient until discharge. No physician shall receive compensation for attendance in the case of any service patient, unless it is payable by a third party. In the case of a paying patient applying for admission who has no attending physician, he/she shall be assigned to the member of the Active Staff on duty in the service to which the illness of the patient indicated assignment.

   On a rotating basis, by a schedule provided to the Medical Staff Office by the Departmental Chairman or Section Director, physicians in all Departments as part of their voluntary service obligation to Saint Francis Healthcare, shall be responsible for the care of patients who present themselves to the Emergency Room (without a physician having privileges at Saint Francis Healthcare), patients referred from the Family Practice Center and related patient care centers, a service patient already admitted who may need a consultation as an outpatient, or a patient in another area of the hospital needing an attending physician. It will further be the obligation of the person assigned to arrange for appropriate coverage for service patients in accordance with Rule #E-2 when he is off call. Failure to meet this obligation shall result in appropriate disciplinary action by the Departmental Chairperson.

6. Evaluation of Patient in the ED: All patients registering in the Emergency Department will be evaluated by an Emergency Physician with the following exceptions:

   a. If a member of the Medical Staff has arranged to meet his/her patient in the Emergency Department, he/she may, instead, evaluate the patient. If the attending physician is not present and the patient's condition becomes unstable while in the Emergency Department, the patient will be evaluated by an Emergency Physician.

   b. Admitted patients who are held in the Emergency Department pending bed availability shall be the responsibility of the admitting physician. If at any time the patient's condition becomes unstable, the Emergency Department Physician will evaluate the patient. The

admitting physician will be called and informed of the patient's status. Admission orders are the responsibility of the admitting physician.

7. Responsibility of the ED Physician: The Emergency Department Physician is responsible for the management and treatment of the patient until the patient is either discharged from the Emergency Department, transferred to care of another physician, admitted to the hospital, or transferred to another facility.

8. Management of Patient in the ED: The attending physician should be consulted by the Emergency Department physician regarding treatment, follow-up, major change in the management of the patient and/or concerning the need for admission to the hospital, when circumstances warrant.

   If the patient's attending physician has not responded, the on-call physician on service shall be contacted. In the event of further delay, the Chairman of the Department or Section Director, if appropriate, are to be called.

   On-Call Physicians called by the Emergency Department must respond within 15 minutes. If there is no response within 15 minutes, the Emergency Department will call the physician again. If there is no response within an additional 15 minutes, the Emergency Department physician will contact other physicians to facilitate expeditious care. The failure of an on-call physician to respond will be reported to the VPMA/CMO.

9. Mandatory Consultation Criteria: To assure that each patient is treated by an appropriately qualified practitioner who is competent and credentialed to deliver the required clinical care the following criteria shall be used to determine circumstances that require consultation by the appropriate medical staff member:

   a. All cases of attempted suicide shall have a psychiatric consult during hospitalization.

   b. Obstetric patients admitted to an intensive care unit should be followed by a practitioner credentialed for obstetrics care and a Medical Staff member credentialed to provide care for an intensive care patient.

   c. Newborns admitted to NICU are required to have a consult with a Neonatologist.

   d. Any time the condition of the patient calls for a procedure, a type of care, or treatment that exceeds the privileges of the Medical Staff member attending the patient, a consult will be requested for a Medical Staff member with that privilege.

   e. Family Practice obstetrical patients with specific diagnoses outlined in the Delineation of Clinical Privileges will require an Obstetrics/Gynecology consult.

10. Consulted physicians: Consulted physicians are expected to perform consultations the same day as requested, or at least within 24 hours unless other satisfactory and specific alternative arrangements are made directly with the requesting physician. The consultant will enter in the EMR or dictate an initial consultation report. For a single consultation visit, the initial consultation report may serve as the final report. If the patient requires additional visits by the consulting physician or if the clinical situation requires ongoing care by the consulting physician, a sign off or discharge consultation report, including post-discharge follow-up plans, must be entered into the EMR or dictated.

11. Appropriate use of Telemetry Beds: To ensure the appropriate use of telemetry beds (excluding ICU), a Medical Director for Critical Care may be appointed by the Hospital. The Medical Director, who must be a member of the Medical staff and Board Certified in Cardiology, will have the authority to implement a triage system, which includes the authority to order discontinue telemetry, and transfer of patients to an alternative inpatient level of care.

12. ICU Critical Care Consult Service: Consistent with the Hospital's goals of improving the quality and efficiency of care provided in the ICU, the hospital will establish an ICU Critical Care Consult Service Pursuant to which Physicians of Physician Group will be consulted by the admitting physician for each ICU patient, except for single system cardiology patients and CT Surgery patients. The Hospital will adopt such policies or procedures as may be required to implement the Consult Service. Physician Group understands and agrees that:

    a. The admitting physician may actively participate in the patient care and decisions; and

    b. The admitting physician has final decision-making authority in all patient care decisions.

    Admission or transfer to the ICU will require that the admitting physician, or their coverage, will directly exam the patient and complete the admitting orders within <u>one hour</u> of the admission. If the patient is not seen within the hour, the admitting physician will be changed to the designated hospitalist covering group and care will continue under their direction until discharge of the patient from the hospital.

F. MANAGEMENT OF INFORMATION

1. Completion of Medical Records: The attending physician shall be held responsible for the preparation of a legible, complete medical record on each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, X-ray studies and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary and discharge note, and follow-up and autopsy report when performed. No medical record shall be filed permanently until it is complete, except on order of the MEC.

    Attending physicians supervising resident physicians must countersign, date and time the history and physical examination, the face sheet and attestation statement, and discharge summaries. All emergency room records of patients evaluated by resident physicians must also be countersigned by the appropriate supervising physician.

    Attending physicians supervising their Allied Health Professionals may not delegate the performance of history and physical examinations except to qualified Physician Assistants (PA) or Nurse Practitioners (NP) and must countersign all history and physicals, orders, progress notes and discharge summaries dictated/written by the assistant within 24 hours. NP's and PA's who have prescriptive authority in Delaware do not require cosigners for progress notes and orders.

2. Completion of Discharge Summary: The physician in attendance at the time of discharge shall be responsible for the medical record including a complete discharge summary which encompasses the entire hospital course and not just the part of the patient's care dating from the time of the transfer. The discharge summary shall include the reason for hospitalization, the significant findings, the procedures performed and treatment rendered the patient's condition on discharge,

and any specific instructions given to the patient and/or family, as pertinent. The discharge summary must be completed electronically or dictated.

A final progress note may be substituted for the discharge summary only in the case of normal newborn infants and uncomplicated obstetric deliveries.

3. Discharge of Patient: The discharge diagnosis must be recorded and electronically signed by the physician at the time of discharge. By electronically signing the discharge order, the date and time of the discharge order will be electronically recorded. If the final diagnosis for some reason cannot be provided, then an explanatory progress note as to why such diagnosis cannot be furnished must be provided on the progress notes with the tentative date of providing the discharge diagnosis.

4. Patient Care Orders: All orders for patient care must be complete, dated, timed, entered and authenticated in electronic format. An order must be entered by the physician or Allied Healthcare Provider privileged to write orders in their respective areas. The following personnel are authorized to receive and transcribe verbal/telephone orders:

    1. Registered Nurse
    2. Registered Pharmacists
    3. Registered Respiratory Therapists and certified Respiratory Therapists
    4. Registered Radiologic Technologists and Registered Diagnostic Medical Sonographers
    5. Registered Dietitians
    6. Medial Laboratory Technologists, Medical Laboratory Technicians, Laboratory Assistants and Laboratory Clerks
    7. Licensed Physical/Occupational/Recreational/Speech Therapists

    Verbal/telephone orders must be entered directly into the EMR as it is heard than immediately read back to the physician/AHP who gave the verbal or telephone order for confirmation of accuracy of the order. In general the use of verbal orders is discouraged due to the potential for medical error and should be handled in an expedited manner. Verbal orders, given in person to the appropriately designated staff, should only be used in emergency situations, and be electronically signed immediately after the emergency. Likewise, the practitioner should sign, date and time telephone orders within 48 hours.

    Verbal orders are to be used infrequently, and should be authenticated by the ordering physician as noted above. Occasionally the ordering physician may not be able to authenticate her/his verbal order, and in such cases, it is acceptable for a covering physician to co-sign, date and time the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for her/his colleague's order as being complete, accurate, and final.

    In order to facilitate patient care, when unable to communicate with a physician, a registered professional nurse, pharmacist, respiratory therapist, physical therapist or other appropriately designated personnel may accept the following delegated or intermediary orders from a representative of a doctor, i.e., a nurse or secretary. The attending physician shall sign, date and time such orders within 48 hours.

    The representative of the doctor may inform the nurse on the unit of the procedure and the posted time. Nurse accepting orders must write under orders the name (at least the first initial and last name) of the physician's representative, date and time.

The physician agreeing to utilize this policy is required to sign, date and time a designated form stating that he/she will accept responsibility for these orders.

Intermediary orders must be renewed annually.

5. Operative Report: All operations performed must be fully described by:

- A comprehensive and complete operative report generated in the EMR.
- In lieu of a complete operative report, a brief post-operative note may be generated immediately in the EMR following surgery with a subsequent complete operative report finished in the EMR the same day.

6. Timelines for Completion of Medical Records: All medical records are required to be complete within thirty (30) days of patient discharge.

A. Notification Process for Incomplete Records:

1) Staff members and residents will be notified on a weekly basis of any incomplete record. The notification will include the patient's name, medical record number, when the record must be completed and the location of the record.

2) A follow-up reminder phone call will be made to Staff members six (6) days prior to the thirty (30) day delinquent date.

3) All members of the surgical staff will receive a written notification and a phone call at twenty one (21) days alerting them that no additional elective surgeries will be scheduled until all outstanding medical records have been completed.

B. Actions:

If a record remains incomplete thirty (30) days after patient discharge, the staff member will be sent a certified notice of Administrative Suspension.

(Administrative Suspension is not reportable to the National Practitioner Data Bank)

Following administrative suspension all admitting privileges will be suspended. Suspended providers may continue to care for currently admitted patients but will not be permitted to take on call duties, admit new patients, or schedule any elective surgeries until the remedies described below have been implemented.

C. Remedies:

1) Complete all delinquent records
2) Pay the existing Medical Staff application fee

7. Property of Hospital Record: All records are the property of the hospital and shall not be taken away without permission of the Chief Executive Officer. In cases of readmission of a patient, previous records shall be available for the use of the attending physician. This shall apply whether the patient be service or private, and whether he be attended by the same physician or another.

8. **CONFIDENTIALITY**: All participants in Credentialing and Peer Review activities shall respect the confidential nature of matters brought before them. In addition, participants shall respect the confidential nature of information reported to or disclosed by the NPDB, and shall <u>not</u> disclose such information in response to a subpoena or a discovery request as such disclosure is prohibited

by law. Requests for such information should be reported to the VPMA/CMO, and appropriate legal action will be initiated in response to such requests.

G. MANAGEMENT OF THE ENVIRONMENT OF CARE

An Emergency Management Plan for mass casualties shall be kept current. In the event of a disaster, the Chairman of this Committee shall be charged with the responsibility of initiating and implementing this plan. The plan for the care of mass casualties will be rehearsed at least twice a year.

H. AUTOPSIES

Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible, or when the cause of the patient's death is uncertain or the death was unexpected. No autopsy shall be performed without the written consent of the legal next of kin of the deceased patient, except as required by law. All autopsies shall be performed by the hospital pathologist, or a physician to whom he/she may delegate this duty.

I. CREDENTIALING, PRIVILEGING AND REAPPOINTMENT

1. Qualification of Consultant: Except in an emergency, consultation with another qualified physician shall be required in all patients whose disease extends beyond or out of the qualifications or specialty of the attending physician.

2. Temporary Privileges for Consults: In order for a Staff member to engage a consultant who is not on the hospital staff, the consultant must obtain temporary privileges from the Chief Executive Officer with the concurrence of the pertinent Department Chairperson and the President of the Medical Staff in accordance with Section I.6 of the Saint Francis Healthcare Credentialing Policy.

3. Supervision:

    a. Direct Supervision requires the supervising physician to be physically present, and to perform an evaluation of the care which is being supervised.

    b. Indirect Supervision requires the physician to be either physically present on the premises or readily available by an electronic device. Readily available necessitates the ability to become physically present within 20 minutes of notification.

4. Use of Allied Health Professional: Members of the Staff who wish permission to use assistants, employed by them, to assist in the care of their own hospitalized patients shall adhere to the Allied Health Professional Policy and the following stipulations:

    a. The staff member must submit an application to the VPMA/CMO. The application form must include details of the employee's qualifications, training, and experience and must state what level of privileges is being requested.

    b. The application must be processed as specified in the Policy and Procedures on Allied Health Professionals.

    c. The extent of activities and degree of supervision shall be recommended by the Credentials Committee after consultation with the Vice President of Nursing.

d. If permission is given to use an assistant, the staff member shall be responsible for limiting the employee to the performance of function within the delineation of permitted activities. The staff member shall assume all liabilities arising out of all functions performed by the employee and shall hold the hospital harmless for activities for the assistant.

J. CODE OF CONDUCT POLICY

1. Policy Statement

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. Thus, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

2. This Policy outlines collegial and educational efforts that can be used by Medical Staff leaders to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the process in the Credentials Policy.

3. This Policy also addresses sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

4. In dealing with all incidents of behavior or behaviors that undermine a culture of safety, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

5. All efforts undertaken pursuant to this Policy shall be part of the Hospital's performance improvement and professional and peer review activities.

2. Examples of Behavior or Behaviors that Undermine a Culture of Safety

To aid in both the education of Medical Staff members and Allied Health Professionals and the enforcement of this Policy, examples of "behavior or behaviors that undermine a culture of safety" include, but are not limited to:

- threatening or abusive language directed at patients, nurses, Hospital personnel, Allied Health Professionals or other physicians (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

- degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;

- profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

- inappropriate physical contact with another individual that is threatening or intimidating;

- derogatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual outside of appropriate Medical Staff and/or administrative channels;

- inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff members or any other individual;

- imposing onerous requirements on the nursing staff or other Hospital employees;

- refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs); and/or

- "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

  (a) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;

  (b) Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;

  (c) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and

  (d) Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

3. **General Guidelines/Principles**

1. Issues of conduct by members of the Medical Staff or Allied Health Professionals (hereinafter referred to as "practitioners") will be addressed in accordance with this Policy. If the matter involves an employed practitioner, hospital management in consultation with appropriate medical staff leaders and legal counsel will determine which of any applicable policies will be applied.

2. This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address concerns about behavior or behaviors that undermine a culture of safety by practitioners. However, a single incident of behavior or behaviors that undermine a culture of safety or a pattern of behavior or behaviors that undermine a culture of safety may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Executive Committee or the elimination of any particular step in the Policy.

3. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the Professional Review Committee/Peer Review Committee, the practitioner's counsel shall not attend any of the meetings described in this Policy.

4. The Medical Staff leadership and Hospital Administration shall provide education to all Medical Staff members and Allied Health Professionals regarding appropriate professional behavior by sending out the policy electronically, use a read receipt and by placing a copy in the new applications and reappointment applications that will go out. The Medical Staff leadership and Hospital Administration shall also make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of behavior or behaviors that undermine a culture of safety and prompt action as appropriate under the circumstances.

4. **Reporting of Behavior or Behaviors that Undermine a Culture of Safety**

1. Nurses and other Hospital employees who observe, or are subjected to, behavior or behaviors that undermine a culture of safety by a practitioner shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, shall notify any member of the Professional Review Committee/Peer Review Committee and also make such reports as are required by applicable Hospital human resources policies. Any practitioner who observes such behavior by another practitioner shall notify any member of the Professional Review Committee/Peer Review Committee directly.

2. The individual who reports an incident shall be requested to document it in writing. If he or she does not wish to do so, the supervisor may document it, after attempting to ascertain the individual's reasons for declining and encouraging the individual to do so.

3. The documentation should include:

a. the date and time of the incident;

b. a factual description of the questionable behavior;

c. the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;

d. the circumstances which precipitated the incident;

e. the names of other witnesses to the incident;

f. consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;

g. any action taken to intervene in, or remedy, the incident; and

h. the name and signature of the individual reporting the matter.

4. The supervisor shall forward the report to the Professional Review Committee/Peer Review Committee.

5. The supervisor shall follow up with the individual who made the report by informing him/her that the matter is being reviewed, thanking him/her for reporting the matter and instructing him/her to report any further incidents of behavior or behaviors that undermine

a culture of safety. The individual shall also be informed that, due to legal confidentiality requirements, no further information can be provided regarding the review of the matter.

5. **Initial Procedure**

1. The Professional Review Committee shall review the report and may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident.

2. If the Professional Review Committee determines that an incident of behavior or behaviors that undermine a culture of safety has likely occurred, the Professional Review Committee has several options available to it, including, but not limited to, the following:

- notify the practitioner that a report has been received and invite the practitioner to meet with one or more members of the Professional Review Committee to discuss it;

- send the practitioner a letter of guidance about the incident;

- educate the practitioner about administrative channels that are available for registering concerns about quality or services, if the practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the practitioner, as appropriate;

- send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing; and/or

- have a Professional Review Committee member(s), or the Professional Review Committee as a group, meet with the practitioner to counsel and educate the individual about the concerns and the necessity to modify the behavior in question.

3. The identity of an individual reporting behavior or behaviors that undermine a culture of safety will generally not be disclosed to the practitioner during these efforts, unless the Professional Review Committee members agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Peer Review Committee and referral to the MEC pursuant to the Bylaws or Credentials Policy.

4. If the Peer Review Committee prepares any documentation for a practitioner's file regarding its efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Peer Review Committee’s documentation.

5. If additional reports are received concerning a practitioner, the Peer Review Committee may continue to utilize the collegial and educational steps noted in this Section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

6. **Referral to Medical Executive Committee**

1. At any point, the Peer Review Committee may refer the matter to the MEC for review and action. The MEC shall be fully apprised of the actions taken by the Peer Review Committee or others to address the concerns. When it makes such a referral, the Peer Review Committee may also suggest a recommended course of action.

2. The MEC may take additional steps to address the concerns including, but not limited to, the following:

   - require the practitioner to meet with the full MEC or a designated subgroup;
   - require the practitioner to meet with specified individuals (including any combination of current or past medical staff leaders, outside consultant(s), the Board Chair or other Board members if medical staff leaders, hospital management and legal counsel determine that board member involvement is reasonably likely to impress upon the practitioner involved the seriousness of the matter and the necessity for voluntary steps to improve);
   - issue of a letter of warning or reprimand;
   - require the physician to complete a behavior modification course;
   - impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it; and/or
   - suspend the practitioner's clinical privileges for 30 days or less.

   The imposition of any of these actions does not entitle the practitioner to a hearing or appeal.

3. The MEC may also direct that a matter be handled pursuant to the Impaired Physician Policy.

4. At any point, the MEC may also make a recommendation regarding the practitioner's continued appointment and clinical privileges that does entitle the practitioner to a hearing as outlined in the Credentials Policy, or may refer the matter to the Board without a recommendation. If the matter is referred to the Board, any further action, including any hearing or appeal, shall be conducted under the direction of the Board.

7. **Sexual Harassment Concerns**

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

1. A meeting shall be held with the practitioner to discuss the incident. If the practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2. If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the MEC for review pursuant to the Credentials Policy.

3. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Peer Review Committee. If the investigation results in a finding that further improper conduct took place, the Peer Review Committee shall refer the matter to the MEC for a formal investigation or other steps in accordance with the Credentials Policy. Such referral shall not preclude other action under applicable hospital human resources policies. Should the MEC make a recommendation that entitles the individual to request a hearing under the Credentials Policy, the individual shall be provided with copies of all relevant reports so that he or she can prepare for the hearing subject to agreement of the practitioner and counsel, if any, not to retaliate in any way.

K. IMPAIRED PHYSICIAN MANAGEMENT POLICY

1. It is the responsibility of the Hospital and its Medical Staff to ensure that its practitioners perform their professional duties in a skillful, competent manner. A practitioner's ability may become limited or impaired by injury, physical disease, alcohol use or chemical dependency, organic or emotional mental illness. As a result, the impaired practitioner may pose a direct or potential threat to themselves and to the health and safety of others.

2. The Hospital and its Medical Staff shall, while monitoring patient care activities, identify the practitioner whose competence may be impaired and assist the practitioner in obtaining treatment, should the condition be amendable to therapy.

3. In dealing with the practitioner, the Hospital and its Medical Staff, recognize the importance of the right to privacy, and shall keep all records confidential except where reporting is required by law, ethical obligations, or when the safety of a patient is threatened.

Procedure:

1. If any individual has a concern that a member of the Medical Staff is impaired, a signed written report should be given to the President of the Medical Staff or designee, the Chairperson of the involved physician's assigned department, or the VPMA/CMO. The report shall include a description of the incident(s) that led to the concern and must be factual in nature.

2. The report shall be given to the Impaired Physician Committee (IPC) for further investigation corroboration, and review. This IPC will be composed of the President of the Medical Staff or designee and the Chairperson of the involved physician's assigned department, and the VPMA/CMO. Depending on the circumstances, they may make a referral to the Physicians Health Committee (PHC), pursue further inquiry, or follow other investigative avenues outlined in these Bylaws.

3. A Licensed Independent Practitioner may also self-refer him/herself to the IPC, by requesting assistance from any one of the IPC members.

4. The Physicians Health Committee is a Committee of the Medical Society of Delaware, which operates under a Memorandum of Understanding with the Board of Medical Practice, Division of Professional Regulation, of the State of Delaware.

5. The PHC will act expeditiously in reviewing the concerns of potential impairment, and provide a confidential report to the VPMA/CMO, detailing the results of the review and the recommendation(s) made.

6. The IPC may then accept, request further deliberation from the PHC, or reject and institute its own investigation, based on the evidence presented and the level of concern for patient safety.

7. If the recommendations of the PHC include that the physician participates in a rehabilitation or treatment program and the physician agrees to abide by the recommendation, the PHC will assist the physician in locating a suitable program.

8. The progress of the ongoing treatment/rehabilitation as specified by the treatment program will be monitored by the PHC and periodic feedback to the VPMA/CMO will be provided.

9. If the practitioner refuses to acknowledge a problem, violates the agreement to begin treatment or remain in treatment or relapses after completion of therapy, then concern for patient safety mandates that the issue be reported to the Peer Review Committee for consideration of disciplinary action.

10. Documentation of the activities involving an impaired physician shall be maintained in the physician's credentials file. The physician shall have an opportunity to provide a written response to the concern about the potential impairment and it will be maintained in the physician's credentials file.

L. PEER REVIEW/MEDICAL STAFF PRACTICE EVALUATIONS POLICY

1. **Purposes**:

The purposes of this Policy include to: (a) establish triggers for focused professional practice evaluation and data elements for ongoing professional practice evaluation to facilitate a meaningful review of the care provided; (b) effectively, efficiently, and fairly evaluate care provided; and (c) provide constructive feedback, education, and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide. This Policy encourages collegial efforts and progressive steps to address issues that may be identified in the professional practice evaluation process. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, informal discussions, education, mentoring, letters of guidance, sharing of comparative data, and Performance Improvement Plans as outlined in this Policy. All collegial efforts and progressive steps are part of the Hospital's confidential peer review activities. These efforts are encouraged, but are not mandatory, and are within the discretion of the Department Chairs and the Peer Review Committee ("PRC").

2. **Medical Staff Oversight:**

This Policy refers to the records and proceedings of the Medical Staff departments and committees which have the responsibility for evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings that relate to this Policy in any way shall be protected from discovery pursuant to applicable law. Ongoing data review and findings about practitioner practice and performance are evaluated by the Department Chair and/or Division Chief with the focus on improvement. The findings are used to provide ongoing feedback and provide information to be used at the time of reappointment to the Medical Staff.

3. **Definitions and General Principles:**

A. Professional Practice Evaluation

1. Ongoing Professional Practice Evaluation (OPPE) means the ongoing review and analysis of data to identify issues and professional practice trends that may impact on quality of care and patient safety on an ongoing basis. The program includes:

a. The evaluation of an individual practitioner's professional performance and includes opportunities to improve care based on recognized standards.

b. Use of multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with Hospital policies, Rules and Regulations and the Medical Staff Bylaws, and clinical standards and the use of rates compared against established benchmarks or norms.

c. Individual feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

2. Focused Professional Practice Evaluation (FPPE) is a process whereby the current competency and professional performance of a practitioner is assessed.

a. FPPE is used to evaluate the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at Saint Francis Healthcare.

b. FPPE is also used when questions arise regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

B. Peer: A peer is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.

C. Proctor: A member in good standing of the active Medical Staff of Saint Francis Healthcare, with unrestricted privileges in the appropriate specialty or subspecialty.

D. Proctoring: For purposes of this Policy, proctoring is a type of focused evaluation to confirm an individual practitioner's competence at the time when he or she requests new privileges, either at initial appointment or as a member of the Medical Staff, or to confirm competence in the case of established practitioners who have been referred for focused review.

E. Time Frames: The time frames specified in this Policy are provided as guidelines. All participants in the process shall use their best efforts to adhere to these guidelines.

F. Conflict of Interest Guidelines: To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest and appearances. Recognizing that peer review involves "peers," the following conflict of interest guidelines shall be used in determining whether and how an individual can participate in the focused professional practice evaluation process.

1. Immediate Family Members. An immediate family member (spouse, parent, child, sibling or in-law) of the practitioner whose care is being reviewed shall not participate in any aspect of the review process except to provide information.

2. Employment by or Contractual Relationship with the Hospital. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not in and of itself preclude an individual from participating in peer review activities.

3. Actual or Potential Conflicts: With respect to a practitioner whose care is under review, actual or potential conflict situations include, but are not limited to, the following:

    a. membership in the same group practice;
    b. having a direct or indirect financial relationship;
    c. being a direct competitor;
    d. close friendship;
    e. a history of personal conflict;
    f. personal involvement in the care of a patient which is subject to review;
    g. raising a concern that triggered the review; or
    h. prior participation in review of the matter at a previous level.

4. Participation in Review Process:

    a. Case Reviewers. Individuals may participate in the review process as case reviewers despite an actual or potential conflict because of the check and balance provided by objective worksheets and the PRC's subsequent review.

    b. PRC Members. Individuals may participate in the review process as PRC members despite an actual or potential conflict because the PRC does not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the PRC Chair has the discretion to recuse a committee member in a particular situation if the Chair believes that the committee member's presence could inhibit discussion of the issue before the committee, or the member may recuse himself or herself.

    c. MEC Members. When the MEC or the Credentials Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, an individual who has an actual or potential conflict as outlined above may provide information to and answer questions posed by the Committee, but shall not participate in the Committee's final deliberation or determination and shall be excused from any meeting during that time. This recusal shall be documented in the minutes. However, the member may provide relevant information and may answer any questions concerning the matter before leaving. The member may be assigned to review a case.

    d. Any member with knowledge of the existence of a potential conflict of interest on the part of any other member may call the conflict of interest to the attention of the committee or department chair. The Chair will make a final determination as to whether the provisions in this section should be triggered.

e. The fact that a department chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

f. The fact that a department or committee member chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

g. Request for Additional Information or Input. At any point in the process outlined in this Policy, information or input may be requested from the practitioner whose care is being reviewed, or from any other practitioner or Hospital employee with personal knowledge of the matter.

h. No Further Review or Action Required. If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter shall be closed. A report of this determination and the reasons supporting it shall be made to the PRC. If information was sought from the practitioner involved, the practitioner shall be notified of the determination.

i. Findings and Recommendations Supported by Evidence Based Research/Clinical Protocols or Guidelines. Whenever possible, the findings of reviewers and the PRC shall be supported by evidence based research, clinical protocols or guidelines.

j. System Process Issues. Quality of care and patient safety depend on many factors in addition to practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the appropriate Hospital Department and/or the Clinical Quality Department. The referral shall be reported to the PRC so that it can monitor the successful resolution of these issues.

k. Tracking of Reviews. The Clinical Quality Department shall track the processing and disposition of matters reviewed pursuant to this Policy. The Department Chairs and PRC shall promptly notify the Clinical Quality Department of their determinations, interventions and referrals.

l. Legal Protection for Reviewers and Proctors. It is the intention of the Hospital and the Medical Staff that the professional practice evaluation process outlined in this Policy be considered patient safety, professional review, and peer review activity within the meaning of the federal Health Care Quality Improvement Act of 1986, and Delaware law. In addition to the protections offered to individuals involved in professional review activities under those laws, such individuals shall be covered under the Hospital's Directors' and Officers' Liability insurance and/or will be indemnified by the Hospital when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital. The Hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising

from his or her acts or omissions in the role of proctor, in accordance with the Saint Francis Healthcare insurance plan.

4. **Confidentiality Principles**:

Professional practice evaluation information is privileged and confidential in accordance with Medical Staff Bylaws and applicable laws and regulations pertaining to confidentiality and non-discoverability.

A. The Hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in a secure location. Provider-specific professional evaluation information includes information related to:

1. Performance data for all dimensions of performance measured for that individual practitioner.

2. The individual practitioner's role in sentinel events, significant incidents, or near misses.

3. Correspondence to the practitioner regarding commendations, comments regarding practice performance, or performance improvement plans.

B. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a Medical Staff leader or a member of a peer review committee. They shall have access to the information only to the extent necessary to carry out their assignment.

C. A physician's quality reappointment file can only be accessed by the VPMA/CMO, the President of the Medical Staff or designee, Department Chairpersons, and members of the Credentials Committee at the time of reappointment. Physicians can access their own files through their Department Chairperson.

D. All individuals involved in the professional practice evaluation process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

E. Communications among those participating in the professional practice evaluation process, including communications with the individual practitioner involved, shall be conducted in a manner reasonably calculated to protect privacy. Correspondence shall be conspicuously marked with the notation "Confidential, to be Opened Only by Addressee."

5. **Methods and Procedures**:

A. OPPE

1. Each department will define for each specialty and subspecialty the appropriate data to be collected for practitioners with privileges in that specialty/subspecialty. Each OPPE data set will be approved by the Chairs of the Departments, Peer Review Committee (PRC) and the Credentials Committee. Where appropriate and relevant, the threshold for each data element is included. In determining the data elements to be collected, the available information system capabilities and the type of data that would reasonably be expected to

reflect clinically-significant issues for each specialty shall be considered. When possible, the thresholds for data elements shall be based on relevant clinical literature.

2. Semi-Annual Reports. An OPPE report for each practitioner shall be prepared at least every six months. A copy shall be placed in the practitioner's file and considered in the reappointment process and in the assessment of the practitioner's competence to exercise the clinical privileges granted. A practitioner's OPPE report shall include:

    a. performance as measured by the relevant data elements;
    b. the number of cases identified for review and the dispositions of those cases;
    c. the number of informational letters sent pursuant to this Policy.

3. Review by Clinical Quality Department.

    a. If the OPPE report reveals that the practitioner's data is within the defined thresholds that have been established and no other issues or concerns are noted, the Clinical Quality Department can provide a copy of the report if requested by the practitioner. This information is being provided to the practitioner solely for information and for use in his or her patient care activities and that no response and no further review are necessary at that time.

    b. If the OPPE report reveals any questions or concerns, the Clinical Quality Department shall provide a copy of the report to the practitioner and indicate that it has been forwarded to the Department Chair for review. The practitioner will also be informed that the Department Chair will contact the practitioner if he or she determines that any response or further review is required.

    c. The Department Chair may review the underlying cases that make up the data or other relevant information to determine if the data reflects any clinical pattern or issue that requires further review. If it does, the Department Chair shall notify the Clinical Quality Department and proceed in accordance with this Policy. If it does not, the Department Chair shall document his or her findings and include them in the practitioner's file along with the OPPE report.

Each OPPE data set may include, but is not limited to, the following types of information:

- Review of operative and other clinical procedures(s) performed and their outcomes;
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay patterns;
- Morbidity and mortality data;
- Practitioner's use of consultants; and
- Compliance with clinical data.

Methods of data collection may include, but are not limited to:

- Periodic chart review;
- Direct observation;

- Monitoring of diagnostic and treatment techniques;
- Discussion with other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel;
- Practice patterns;
- Aggregated and analyses of resource usage;
- Patient outcomes;
- Reported Concerns from patients or staff; and
- Comparative performance measurements from available databases.

If the data is generated by the Clinical Quality Department from their databases, this data will be sent to the Medical Affairs office for inclusion in the practitioner's file. The Medical Affairs office will forward the information to the appropriate Department Chair for review.

If the data cannot be obtained from the hospital databases, it will be the responsibility of the individual department/division or their designee to collect the data. This data will be reviewed by the Department Chair and forwarded to the Medical Affairs office for inclusion in the practitioner's file.

The Department Chair will review the collected data and will complete the attached form (Exhibit A) and send it to the Medical Affairs office for inclusion in the practitioner's file. This data will be collected *two* (2) times each year.

Relevant information from the OPPE data sets will be utilized as follows:

- Data shall be reviewed by the Clinical Quality Department and integrated into performance improvement initiatives; and

- Upon determination by the VPMA/CMO, an OPPE data set may result in a focused review of a practitioner under the FPPE process.

The activities of the ongoing professional practice evaluations are considered privileged and confidential. This continuous practice evaluation information will be considered in decisions to revise, revoke, or renew existing privileges in accordance with the applicable provisions of the Credentialing Policy.

B. FPPE for New Privileges

1. Under the direction of the Department Chair, each specialty/subspecialty shall prepare a brief Proctoring Plan for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The Plan will be reviewed and updated as needed and will include the proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source is required. The Medical Affairs office shall maintain copies of all Proctoring Plans.

   Proctors may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form.

a. **Prospective proctoring:** Presentation of cases with planned outline of treatment for prospective review of case documentation and proposed treatment orders.

b. **Concurrent proctoring:** Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

c. **Retrospective evaluation:** Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient's care.

Each of the above methods may include observation of:

a. History and physical;
b. Diagnosis and justification;
c. Proposed treatment or procedure and its indications;
d. Continuity of care provided to the patients;
e. Appropriateness of procedures, tests, and medications prescribed;
f. Appropriate use of consultants;
g. Appropriateness of length of stay;
h. Adequacy of progress notes;
i. Adequacy of operative notes;
j. Discharge summary;
k. Timely completion of medical records;
l. Appropriately signed consents;
m. Technical skills/knowledge (as appropriate);
n. Use of blood and blood products;
o. Punctuality and conduct in OR (as appropriate);
p. Pre- and post-operative care; and
q. Management of complications.

Proctoring data from the above methods can be obtained for all admissions of the practitioner or from a random sample. Data may be individual (i.e., case-specific) or aggregate "rate" date from multiple cases. Data may be derived from information specially obtained for FPPE or for other purposes. The data obtained by the proctor will be recorded in a FPPE form that has been approved by the Credentials Committee in an effort to structure the proctoring data for consistency and reliability.

Proctoring shall begin with the applicant's first admission or encounter related to a new privilege which, after approval with proctoring, has been granted by the MEC and the Board. The duration of proctoring shall be a specific period of time or for a specific number of cases as specified in the Plan and may differ based upon the levels of experience described below.

The practitioner's previous experience may be a factor in determining the approach and extent of proctoring needed to confirm current competence. The practitioner's experience may fall into one of the following classes:

a. A recent training program graduate (within one year)

b. A practitioner with experience of less than five (5) years on another Medical Staff

c. A practitioner with experience of greater than five (5) years on another Medical Staff

d. A gap in continuity of practice

Practitioners in classes a), b), and d) would be candidates for full proctoring programs. Practitioners in class c) may be candidates for limited proctoring upon recommendation of the Department Chair based upon knowledge of the practitioner.

2**.** **Responsibilities of Proctors**:

The proctor shall:

- Personally perform the proctoring methods specified in the Proctoring Plan, obtain sourcedata as specified in the Proctoring Plan and complete the Proctoring forms;
- Complete a summary report of the Proctoring forms in a format prescribed by the Department Chair;
- Protect the confidentiality of the proctoring results, forms and summary report;'
- Deliver the completed proctoring forms and summary report to the Medical Affairs office within seven (7) days of the conclusion of the proctoring period.

If at any time during the proctoring period the proctor has concerns about the practitioner's competency related to the specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the Department Chair and provide specific factual information, observation and data to the Chair.

3. **Rights and Responsibilities of Practitioner Being Proctored**:

The practitioner being proctored shall do the following as defined in the Proctoring Plan:

- For prospective and concurrent proctoring, notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as is reasonably possible.
- Provide the proctor with a list of patients, medical record numbers, any clinical information requested including pertinent physical findings; complete medical chart; pertinent x-ray and lab results; the planned course of treatment or management, operative reports, consultations, and discharge summaries. Documentation must be made available timely so as to conform to the method of proctoring.
- Inform the proctor of any unusual incident(s) associated with his or her patients.

The practitioner under review has the right to:

- Request from the Department Chair or VPMA/CMO if the Department Chair is the proctor, a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. Such requests shall not unreasonably be denied.

- Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of Proctoring forms and the summary report to the Department Chair. The proctoring period will automatically extend for 60 days if the summary report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not submitted to the Department Chair at the end of the automatic extension, the provisional privileges subject to proctoring shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

4. **Responsibilities of the Department Chair**:

Each Department Chair shall:

- Establish for each specialty and subspecialty within their Department appropriate proctoring methods, data sources, duration of proctoring or minimum number of cases to be proctored. When there are inter-departmental privileges, the Credentials Committee shall determine the minimum number of cases, procedures or time period to be reviewed if there is a disagreement between Chairs.

- Assign a proctor to each applicant at the time practitioner is recommended to Credentials Committee for approval.

- Review the medical records of the patient(s) treated by the practitioner being proctored and any other information provided, if, at any time during the proctoring period or at the end of the proctoring period, the proctor notifies the Department Chair that he or she has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s). The Department Chair shall interview the practitioner and the Department Chair shall then do one of the following:

    a. Intervene and address a conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient and/or appoint a new proctor;

    b. Refer the case(s) to the PRC for peer review; or

    c. Recommend to the Credentials Committee that additional or revised proctoring requirements be required.

        - At the request of the practitioner or the proctor, recommend extension of the evaluation period to the Credentials Committee if the practitioner, through no fault of his/her own, has not presented the minimum number of cases or procedures within the time required by the Plan.

        - At the conclusion of the proctoring period, review the Proctoring forms and summary report of the proctor, submit the summary report to the Medical Affairs office, and make a recommendation to the Credentials

Committee for approval of privileges, additional proctoring or denial of privileges.

5. **Responsibilities of the Medical Affairs Office**:

The Medical Affairs Office shall do the following:

- Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:

  a. Copy of the privilege form

  b. Name, address and telephone numbers of both the practitioner being proctored and the proctor

  c. Copy of this Policy and the Department's Specialty Proctoring Plan

  d. Proctoring form to be completed by the sponsor

  e. Provide information to appropriate hospital department about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed

  f. Periodically submit a report to the Credentials Committee and the MEC of proctorship activity for all practitioners being proctored

  g. At the conclusion of the proctoring period, submit the summary report to the Credentials Committee and the MEC.

Responsibilities of the Credentials Committee

The Credentials Committee is charged with monitoring compliance with the proctoring Policy and procedures. It accomplishes this oversight by receiving regular status reports related to the progress of all practitioners required to be proctored, as well as any issues or problems involved in implementing this Policy and procedure. The Department Chair shall be responsible for overseeing the proctoring process for all applicants assigned to their department and seeing that the process is completed within a timely fashion. Based on the evaluation of the practitioner's current clinical competence, practice behavior and ability to perform the requested privilege, the Credentials Committee shall determine whether to impose additional proctoring requirements and/or extend the proctoring period, and shall recommend to the MEC whether privileges shall be approved at the conclusion of proctoring. The proctored practitioner shall be entitled to request a hearing on a denial of privileges in accordance with the Credentialing Policy.

6. **Principle of Proctoring**:

The proctor's role is typically that of an evaluator, not of a consultant or mentor. A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the Medical Center. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.

C. **FPPE for Established Practitioners**

1. **FPPE Triggers**. The FPPE process may be triggered by any of the following events:

   a. Specialty-Specific Triggers. Each Department shall identify outcomes, clinical occurrences, or complications that will trigger FPPE. The triggers identified by the Departments shall be approved by the PRC.

   b. Other Indicators approved by the PRC. The Clinical Effectiveness staff will perform ongoing screening to identify cases.

   c. A determination by the VPMA/CMO that a focused review is appropriate, based upon the review of any of the following:

      i. Ethics/Hotline calls

      ii. Reported concerns from other clinicians or members of the health care team

      iii. Root cause analysis following a sentinel event involving an individual practitioner's professional performance;

      iv. Patient complaints referred by the Patient Representative

      v. A Department Chair's determination that OPPE data reveal a practice pattern or trend that warrants further review;

      vi. Identification by a Medical Staff committee of a clinical trend or specific case or cases that require further review;

      vii. Cases identified as litigation risks that are referred by Risk Management;

      viii. Corporate compliance issues (e.g., medical necessity) referred through the Compliance Officer or otherwise; and

      ix. A trend of noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols or Core, SCIP, DVT-prevention or other quality measures resulting in more than two informational letters being sent within a six-month period.

2. **Physician Review**:

   a. Cases that fall out of the screening process will be directed to the Department Chair or Leadership Council for initial review.

   b. The Department Chair may perform the initial review personally and complete an appropriate review form or shall assign the review to another practitioner in the Department who has the clinical expertise necessary to evaluate the care provided. The initial review shall be completed within 30 days. Following review, the Department Chair may:

i. Determine that no further review or action is required;

ii. Send an educational letter;

iii. Conduct a collegial intervention with the practitioner; or

iv. Refer the matter to the PRC or the MEC.

a. Cases may be referred to the VPMA/CMO if they are administratively complex, which includes those:

i. That require immediate or expedited review;

ii. That involve practitioners from two or more Departments;

iii. That involve a Department Chair;

iv. That involve professional conduct;

v. That may involve a practitioner health issue;

vi. Where a pattern appears to have developed despite prior attempts at collegial intervention/education; or

vii. Where participation in a performance improvement plan does not seem to have addressed identified concerns.

b. Guidelines for External Review. An external review may be arranged by the VPMA/CMO. If a decision is made to seek an external review, the practitioner involved shall be notified of that decision and the cases to be sent for external review.

i. The Department Chair is not a peer or all peers are members of the same group as the physician whose case is being reviewed;

ii. There are ambiguous or conflicting findings by internal reviewers;

iii. The clinical expertise needed to conduct a review is not available on the Medical Staff; or

iv. An outside review is advisable to minimize potential allegations of bias, even if unfounded.

3. **Peer Review Committee Review**:

a. Review of Prior Determinations. The PRC shall review reports from the Department Chairs for all cases where it was determined that (i) no further review or action was required, or (ii) an educational letter or collegial intervention was appropriate to address the issues presented. If the PRC has concerns about any such determination, it may:

i. Send the matter back to the Department Chair with its questions or concerns and ask that the matter be reconsidered and findings reported back to it within 14 days;

ii. Ask an individual Medical Staff member, another Medical Staff committee or Hospital Department to review the matter and report back to the PRC within 30 days; or

iii. Review the matter itself.

b. Cases Referred to the PRC for Further Review

i. The PRC shall review matters referred to it along with all supporting documentation and determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the PRC may assign review to a practitioner on the Medical Staff with the appropriate clinical expertise or, in consultation with the VPMA/CMO CEO, arrange for an external review.

ii. Cases brought to the PRC may be scheduled for a peer review session.

1. Peers are defined as physicians with similar specialties (i.e., Radiology, Medicine, Orthopedics, etc.);

2. Participants in the peer review process are appointed by each Department Chair;

3. Departmental Peer Review sessions are conducted periodically as required by the volume of cases to be reviewed, but should at least occur within two (2) months of a case requiring review; and

4. Peer Review sessions should have at least two (2) peers to meet along with the Chair.

iii. Peer Review sessions are conducted for the purpose of providing additional, confidential review and feedback.

iv. If this individual fails to respond to a PRC request for information or a personal appearance at a peer review session, within 30 days, the PRC will make a determination without his/her response.

v. The PRC will review all Peer Review Session findings and will make recommendations.

1. As appropriate, the PRC may share aggregate data or provide Grand Round presentations on identified issues of common concern. If a specific case is identified as part of the focused professional practice evaluation process that would have educational benefit for all members of a particular Department or for members of several Departments, the PRC Chair may direct

that the case be presented in an educational session and that members of the relevant Departments be invited to attend the session. The particular practitioner(s) who provided care in the case shall be informed that the case is to be presented in an educational session at least seven days prior to the session. Information identifying the practitioner(s) shall be removed prior to the presentation, unless the practitioner(s) request otherwise. Documentation of the educational session shall be forwarded to the PRC for its review.

2. When review forms are complete and action follow-up has occurred, the review forms will be filed in the physician's quality reappointment file.

vi. Determinations and Interventions: The PRC may:

1. Determine that no further review or action is required;
2. Send an educational letter;
3. Conduct a collegial intervention with the practitioner;
4. Develop a Performance Improvement Plan; or
5. Refer a matter to the MEC.

vii. Forms. The PRC shall approve forms to implement this Policy. Individuals performing a function pursuant to this Policy shall use the form approved by the PRC for that function.

4. **Non-Medical Issues Review**:

Any major non-medical issues such as inappropriate management of the medical record or non-compliance with medical staff bylaws and/or rules and regulations will also be referred to the Department Chair for review. Issues involving behavior will be handled pursuant to the Code of Conduct Policy. These issues will be placed in the physician's quality reappointment file.

5. **Reappointment and Trending**:

At time of reappointment and any time a trend or pattern becomes apparent between reappointments, the file will be referred to the PRC for review and appropriate action.

6. **Focused Reviews**:

a. Physicians may be subject to a focused review under the following circumstances:

i. Physician's performance raises quality or safety concerns, or

ii. Three or more individual issues are referred to Risk Management or Clinical Quality Departments during a two-year period, or

iii. Through screening, the physician is found to have recurring outlier activity, or

iv. A combination of (ii) and (iii) above is noted.

b. Once concerns are referred to the PRC, it will determine the appropriate focused review plan. The VPMA/CMO in consultation with the Department Chair and PRC Chair may prepare a Plan specific to the basis for the focused review. The VPMA/CMO shall notify the practitioner of the focused review and provide a copy of the Plan.

c. The plan may include, but is not limited to, the following:

i. A Peer Review Session.

ii. A referral to the Practitioner Health Committee, as outlined in J. Practitioner Health Management Policy.

iii. A recommendation for an investigation as outlined in the Credentialing Policy.

d. If an opportunity for improvement is found, then the physician in question will have an opportunity to meet with the PRC.

e. The time frame for completing the focused review process will be no longer than 120 days.

7. **Medical Executive Committee Review**:

Issues that are unable to be resolved at the Committee/Department level may be referred to the MEC. The Department Chair (in consultation with the President of the Medical Staff and VPMA/CMO) may refer a matter to the MEC if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, or if the matter involves a very serious incident. In addition, the PRC may refer a matter to the MEC if it determines that a PIP may not be adequate to address the issues identified, or the individual refuses to participate in a PIP developed by the PRC or fails to abide by a PIP. The MEC shall conduct its review in accordance with the Medical Staff Credentials Policy.

8. **Non-Compliance with Medical Staff Rules, Regulations and Policies, or Failure to Follow Clinical Protocols**:

The PRC shall identify specific situations that are conducive to being addressed with a practitioner through an educational letter. These situations include the following:

a. A practitioner failed to comply with Medical Staff Rules and Regulations or other Hospital or Medical Staff policies; or

b. An adopted protocol or guideline was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol or guideline.

In these situations, the VPMA/CMO shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in doing so. The letter shall be signed by the Department Chair or the Chair of the PRC, a copy shall be placed in the practitioner's confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner's competence to exercise the clinical privileges granted. If more than two letters are sent during a six-month period, the matter may then be referred to the PRC.

9. **Notice to and Input from Practitioners**:

An opportunity for practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

a. Notice. No intervention (informational/educational letter, collegial intervention, or Performance Improvement Plan) shall be implemented until the practitioner is first notified of the specific concerns identified and given an opportunity to provide input. The practitioner shall also be notified when the Department Chair refers a matter to the PRC. The notice to the practitioner shall include a time frame for the practitioner to provide the requested input.

b. Input. The practitioner may provide input through a written description and explanation of the care provided, responding to any specific questions posed by the Department Chair, or PRC, and/or by meeting in person with individuals specified in the notice.

c. Failure to Provide Requested Input.

(1) If the practitioner fails to provide input requested by the Leadership Council or the Department Chair within the time frame specified, the review shall proceed without the practitioner's input.

(2) If the practitioner fails to provide input requested by the PRC within the time frame specified, the practitioner's clinical privileges shall be considered automatically relinquished until the requested input is provided, in accordance with Credentials Policy.

10. **Interventions to Address Identified Concerns**:

When concerns regarding a practitioner's clinical practice are identified, the following interventions may be implemented to address those concerns.

a. Informational Letter. For specific situations that are identified by the PRC (e.g., failure to comply with Medical Staff Rules and Regulations requirements), the VPMA/CMO may prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it. A copy shall be placed in the practitioner's confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner's competence to exercise the clinical privileges granted. If more than two letters are sent during a six-month period, the matter shall be subject to more focused review. Informational letters may be signed by the Department Chair or the Chair of the PRC.

b. Educational Letter. An educational letter may be sent to the practitioner involved that describes the opportunities for improvement that were identified in the care reviewed and offer recommendations for future practice. A copy of the letter will be included in the practitioner's file along with any response that he or she would like to offer. Educational letters may be sent by a Department Chair or the PRC. If the letter is sent by the Department Chair, the PRC shall be informed of the substance of the letter.

c. Collegial Intervention. Collegial intervention means a face-to-face discussion between the practitioner and one or more Medical Staff Leaders, followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's future

practice. A copy of the follow-up letter will be included in the practitioner's file along with any response that he or she would like to offer. If the collegial intervention is conducted or facilitated by the Department Chair, the PRC shall be informed of the substance of the discussion and the follow-up letter. A collegial intervention may be conducted by the Department Chair or the PRC personally or they may facilitate an appropriate and timely collegial intervention by designees. The Department Chair and PRC shall be informed of the substance of any collegial intervention and the follow-up letter, regardless of who conducts or facilitates it.

d. Performance Improvement Plan ("PIP"). The PRC may determine that it is necessary to develop a Performance Improvement Plan for the practitioner. To the extent possible, a PIP shall be for a defined number of cases. The plan shall specify how the practitioner's compliance with, and results of, the PIP shall be monitored. The practitioner shall have an opportunity to provide input into the development and implementation of the PIP.

The PIP will be personally discussed with the practitioner and presented in writing, with a copy being placed in the practitioner's file. The practitioner must agree in writing to participate constructively in the PIP. If the practitioner refuses to do so, the matter shall be referred to the MEC.

Until the PRC has determined that the practitioner has complied with all elements of the PIP and that concerns about the practitioner's practice have been adequately addressed, the matter shall remain on the PRC's agenda and the practitioner's progress on the PIP shall be monitored.

A PIP may include, but is not limited to, the following:

i. Additional Education/CME, which means that, within a specified period of time, the practitioner must arrange for education or CME of a duration and type specified by the PRC. The educational activity/program may be chosen by the PRC or by the practitioner. If the activity/program is chosen by the practitioner, it must be approved by the PRC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.

ii. Focused Prospective Review, which means that a certain number of the practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the practitioner).

iii. Second Opinions/Consultations, which means that before the practitioner proceeds with a particular treatment plan or procedure, he or she must obtain a second opinion or consultation from a Medical Staff member(s) approved by the PRC. The practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the PRC.

iv. Concurrent Proctoring, which means that a certain number of the practitioner's future cases of a particular type must be personally proctored by a Medical Staff member(s) approved by the PRC, or by an appropriately credentialed individual from outside of the Medical Staff approved by the PRC. The proctor must be present before the case is started and must remain throughout the duration of the case or must personally assess the patient and be available throughout the course of treatment. Proctor(s) must complete the review form specified by the PRC.

v. Additional Training, which means that, within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the PRC. The training program must be approved by the PRC. The practitioner must execute a release to allow the PRC to communicate information to, and receive information from, the selected program. The practitioner must successfully complete the training within another specified period of time. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the practitioner's current competence, skill, judgment and technique to the PRC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.

vi. Participation in a Formal Evaluation/Assessment Program, which means that, within a specified period of time, the practitioner must enroll in an assessment program identified by the PRC and must then complete the program within another specified time period. The practitioner must execute a release to allow the PRC to communicate information to, and receive information from, the selected program. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.

vii. Educational Leave of Absence, which means that the practitioner voluntarily agrees to a leave of absence during which time the practitioner completes an education/training program of a duration and type specified by the PRC.

viii. Other elements not specifically listed may be included in a PIP. The PRC has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the practitioner to improve his or her clinical practice and to protect patients.

11. **Professional Practice Evaluation Reports**:

a. Practitioner FPPE History Reports. A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past two years and their dispositions shall be generated for each practitioner for consideration and evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process.

b. Reports to MEC and Board. The Clinical Quality Department shall prepare reports at least quarterly showing the aggregate number of cases reviewed through the PPE process, the timeliness of the reviews, the dispositions of those matters, and, when applicable, the effect of the process on patient outcomes.

c. Reports on Request. The Clinical Quality Department shall prepare reports as requested by the Department Chairs, PRC, MEC, Hospital management, or the Board.

i. A practitioner failed to comply with Medical Staff Rules and Regulations or other Hospital or Medical Staff policies; or

ii. An adopted protocol was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol.

In these situations, the Clinical Quality Department shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it.

The letter may be signed by the Department Chair or PRC Chair. A copy shall be placed in the practitioner's confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner's competence to exercise the clinical privileges granted. If more than two letters are sent during the six-month period covered by the OPPE report, the matter shall be reviewed as in 5.C.1(ix).

M. POLICY FOR SUPERVISING RESIDENTS

PURPOSE:

To ensure the safety and quality of care for our patients, residents must be supervised by qualified Medical Staff members.

POLICY:

1. **DEFINITIONS:**

- Residents are defined as physicians who are part of an organized experience of postgraduate education (residency training) leading to a Board Certification designation who work under an institutional license.

- Residency training is an educational experience designed to offer residents the opportunity to participate in the clinical evaluation and care of patients in a variety of patient care settings. All aspects of patient care rendered by resident physicians must receive close supervision.

- The supervisory physician is defined as a member of the Medical Staff who has immediate oversight responsibility of all aspects of patient care rendered by students, interns and residents. In most cases, the supervisory physician is also the attending physician or consultant on the case in all circumstances the supervising physician must have competency in the procedure being supervised.

2. **ROLES AND RESPONSIBILITIES**:

The Program Director of the Family Practice Residency will be in charge of delineating the roles, responsibilities and patient care activities of all residents. These activities are delineated in Administrative Policy.

The Residency Program Director will communicate with the MEC on a quarterly basis through the Education and House Staff Committee regarding the clinical performance and privileging of the residents. The Residency Director will submit an annual report in June of each year regarding the Family Practice Residency and the advancement of the residents through the training program.

All Supervisors will communicate with the Residency Program Director to determine the level of resident involvement and independence in delivering patient care. All aspects of patient care are ultimately the responsibility of the attending physician and involved consultants. Attending physicians have the right to prohibit resident participation in the care of their patients without penalty. When allowing care of their patients by residents they do not relinquish their right or responsibilities to: examine and interview, admit or discharge their patients; or to correct resident medical record entries deemed to be erroneous or misleading by crossing through the erroneous statement and initialing the change. The attending physician and consulting physicians must review all entries by house staff in the medical record on a daily basis and make any necessary corrections in the entries. Attending and consultant physicians must document that

they have personally performed the key components of each medical encounter in order to maintain compliance with this policy.

The goal of residency training is to develop resident physicians into independent practitioners by allowing increasing responsibility in the assessment of patients and the development and implementation of therapeutic strategies. However, it remains the responsibility of all participating staff physicians to closely supervise house staff in the care of patients.

When a resident is involved in the care of a patient, it is the resident's responsibility to communicate effectively with their supervising physician regarding the findings of their evaluation, physical examination, interpretation of diagnostic tests, and intended interventions on a continuous basis. House staff must always notify the appropriate attending or consultant physicians of any change in a patient's condition or prior to initiating changes in a patient's treatment.

3. PRIVILEGES GRANTED TO ALL FAMILY PRACTICE RESIDENTS

Having received admission to the Family Practice Residency, all Family Practice Residents will be permitted to perform the following with supervision as noted.

Admission History and Physicals/Consultations:

Residents may perform history and physical examinations, and consultations without the attending physician being physically present. It is the responsibility of the resident to discuss their findings with the attending physician upon completion of their examination. The attending physician must confirm the key portions of the history and physical exam, make additions and corrections in the documented history and physical exam, and co-sign the resident's documentation.

Daily Progress Notes:

Residents may evaluate and write daily progress notes without the attending physician being physically present. It is the responsibility of the resident to discuss their findings and treatment plans documented in their progress note with the attending physician on a daily basis, or more often as prescribed above, when a patient's condition changes, or prior to initiating changes in a patient's treatment. The attending physician must perform the key portions of the exam and confirm the resident's documentation in the progress note on a daily basis. All documentation by house staff and attending physicians must be legible to those who use the medical record, including signatures. All entries must be signed, dated and timed.

Attending and consulting physicians must make additions and corrections in the daily progress notes and signify these with initials and a date and time of the additions to the medical record. Corrections should be performed by drawing a single line through items of concern and placing additional notes along the margins of the page or in a new section of the progress note. Initials, dates and time must be placed next to all corrections and additions to the medical record.

Daily orders:

Residents may write daily orders on the patients for whom they are participating in the care. These orders will be implemented without the co-signature of an attending or consulting physician. It is the responsibility of the resident to discuss their orders with the attending physician or the consulting physician and upper year resident if a first year resident is writing the orders. Attending, and consulting physicians may write orders in the patient's chart on all teaching cases. Residents should notify the appropriate nursing or support staff of orders entered into the chart to facilitate timely patient care. Residents are encouraged to evaluate

all patients for whom they are initiating orders. However if it is clinically appropriate, residents are allowed to place "verbal" orders over the phone. All phone orders must be signed, dated and timed within the guidelines set forth in the bylaws.

Occurrence Reports:

If the situation occurs where a resident is called upon to fill out an Occurrence Report on a patient, the resident will not refer to submission of the report in the progress notes, or in any portion of the medical record.

4. SPECIAL PRIVILEGES GRANTED TO FAMILY PRACTICE RESIDENTS:

PGY2 & PGY3 Advancement

After preparation by the Program Director, the Education and House Staff Committee will establish criteria for advancement. Near the end of every academic year, the Education and House Staff Committee will review all residents according to the criteria. Following their evaluation and determination, a recommendation will be made for each resident that will include a determination for advancement to PGY2 or PGY3 status.

Procedural Privileging

Residents should be supervised by the physical presence of the attending physician during all procedures, which are specified by the Residency Program Director. To perform procedures under indirect supervision, the resident must have documented observed competency, which is verified by the Program Director, and approved by the Education and House Staff Committee and MEC.

To establish residency procedural privileging, the Program Director will develop a list of procedures that the residents may be privileged to perform independent of the physical presence of the attending physician (indirect supervision.) This list must be developed in conjunction with the Credentials Committee, so that criteria for providing procedural credentialing are consistent throughout the institution. Once established, these criteria may be applied by the Education and House Staff Committee to allow Residents special procedural privileging. Notification of special privileges would be provided from the Education and House Staff to the MEC. The Residency Program Director will review these lists on an annual basis and report his/her findings at the Education and House Staff Committee.

The resident will keep track of all completed procedures on a form supplied by the Residency Program and submit to the Residency Director on a monthly basis. Once the resident has performed the appropriate number of procedures in a competent fashion, the Program Director will present the resident's documentation to the Education and House Staff for further action.

A “Certification book” will be kept on all nursing stations or in Meditech identifying those residents who are certified to perform procedures. Nurses are instructed to check this book or database each time a resident is requesting to perform one of the specified procedures.

N. POLICY FOR MEDICAL STAFF PRACTICE EVALUATIONS

PURPOSE:

To assure that Saint Francis Healthcare, through the activities of its Medical Staff, assesses the ongoing professional practice and competence of its Medical Staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice and care.

MEDICAL STAFF OVERSIGHT:

This policy refers to the records and proceedings of the Medical Staff, which has the responsibility for evaluation and improvement of the quality of care rendered in the Hospital. The records and proceedings of the Medical Staff that relate to this policy in any way shall be protected from discovery pursuant to applicable law. Ongoing data review and findings about practitioner practice and performance are evaluated by the Department Chair and/or Division Chief with the focus on improvement. The findings are used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff.

DEFINITIONS:

A. Professional Practice Evaluation

1. Ongoing Professional Practice Evaluation (OPPE) is a program that allows the Medical Staff to identify professional practice trends that impact on quality of care and patient safety on an ongoing basis. The program includes:

    a. The evaluation of an individual practitioner's professional performance and includes opportunities to improve care based on recognized standards.

    b. Use of multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data, compliance with Hospital policies, Rules and Regulations and the Medical Staff Bylaws, and clinical standards and the use of rates compared against established benchmarks or norms.

    c. Individual evaluation based on generally recognized standards of care. This process provided practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

2. Focused Professional Practice Evaluation (FPPE) is a process whereby the Medical Staff evaluates the competency and professional performance of a practitioner.

    a. FPPE is used to evaluate the privilege-specific competence of a practitioner that does not have documented evidence of competently performing the requested privilege at Saint Francis Healthcare.

    b. FPPE is also used when questions arise regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

B. Peer: A peer is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter.

C. Proctor: A member in good standing of the active Medical Staff of Saint Francis Healthcare, with unrestricted privileges in the appropriate specialty or subspecialty.

D. Proctoring: For purposes of this policy, proctoring is a focused evaluation to confirm an individual practitioner's competence at the time when he or she requests new privileges, either at initial

appointment or as a member of the Medical Staff, or to confirm competence in the case of established practitioners who have been referred for focused review.

E. Conflict of Interest

1. A member of the Medical Staff assigned to perform a professional practice evaluation may have a conflict of interest if he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the practitioner involved as direct competitor or partner.

2. It is the individual reviewer's obligation to disclose the potential conflict to the Department Chair or VPMA/CMO.

3. It the responsibility of the Department Chair and VPMA/CMO to determine whether the conflict would prevent the individual from participating, and the extent of that participation if allowed.

PRINCIPLES:

Professional practice evaluation information is privileged and confidential in accordance with Medical Staff Bylaws, state and federal laws and regulations, and regulations pertaining to confidentiality and non-discoverability.

1. The Hospital will keep provider-specific professional practice evaluation and other quality information concerning a practitioner in a secure location. Provider-specific professional evaluation information includes information related to:

   a. Performance data for all dimensions of performance measured for that individual practitioner.

   b. The individual practitioner's role in sentinel events, significant incidents, or near misses.

   c. Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.

2. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information, based upon their responsibilities as a Medical Staff leader or a member of a peer review committee. They shall have access to the information only to the extent necessary to carry out their assignment.

METHODS AND PROCEDURES:

1. **OPPE**

Each department will define for each specialty and subspecialty the appropriate data to be collected for practitioners with privileges in that specialty/subspecialty. Each OPPE data set will be approved by the Chair of the Department and the Credentials Committee.

Each OPPE data set may include, but is not limited to, the following types of information:

- Review of operative and other clinical procedures(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns

- Morbidity and mortality data
- Practitioner's use of consultants
- Compliance with clinical data

Methods of data collection may include, but are not limited to:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel
- Practice patterns
- Aggregated and analyses of resource usage
- Patient outcomes
- Complaints from patients or staff
- Comparative performance measurements from available databases

If the data is generated by the Clinical Quality Department from their databases, this data will be sent to the Medical Affairs office for inclusion in the practitioner's file. The Medical Affairs office will forward the information to the appropriate Department Chair for review.

If the data cannot be obtained from the hospital databases, it will be the responsibility of the individual department/division to collect the data. This data will be reviewed by the Department Chair and forwarded to the Medical Affairs office for inclusion in the practitioner's file.

The Department Chair will review the collected data and will complete the attached form (Exhibit A) and send it to the Medical Affairs office for inclusion in the practitioner's file. OPPE required on an ongoing basis within the 2 year reappointment period.

Relevant information from the OPPE data sets will be utilized as follows:

- Data shall be reviewed by the Clinical Quality Department and integrated into performance improvement initiatives

- Upon determination by the VPMA/CMO, an OPPE data set may result in a focused review of a practitioner under the FPPE process;

- Data shall be used to determine whether to continue, limit or revoke any existing privileges(s) and shall be placed in the practitioner's file for consideration at the time of reappointment.

The activities of the ongoing professional practice evaluations are considered privileged and confidential. This continuous practice evaluation information will be considered in decisions to revise, revoke, or renew existing privileges in accordance with the reappointment provisions of the Credentialing Manual.

2. **FPPE for Established Practitioners**

Focused review may be utilized to obtain sufficient information regarding competence of an established practitioner under the following circumstances:

A determination by the VPMA/CMO or designee that a focused review is appropriate, based upon the review of any of the following:

a. Ethics/Hotline calls
b. Complaints from other clinicians or members of the health care team
c. Root cause analysis
d. Performance improvement data indicating unfavorable trend associated with practitioner
e. Patient complaints
f. OPPE results

The VPMA/CMO shall prepare a Plan for focused review, which shall contain all of the elements of a Performance Improvement Plan under this policy, but shall be specific to the basis for the focused review. The VPMA/CMO shall notify the practitioner of the focused review and provide a copy of the Plan. The VPMA/CMO may perform the focused review or appoint a proctor. At the conclusion of the focused review, the VPMA/CMO shall evaluate the results of the focused review and if he/she determines further investigation is required, the VPMA/CMO may submit a request for a corrective action to the President of the Medical Staff pursuant to the process outlined in the Credentialing Manual. At the conclusion of the focused review, the proctor shall return the proctoring forms or summary report to the Credentials Committee.

3. **FPPE for New Privileges**

Under the direction of the Department Chair, each specialty/subspecialty shall require a minimum of 3 Focused Professional Practice evaluations be completed. For Surgeons higher risk procedures will be used for the FPPE. This will be required for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source may be required, shall be identified on a case by case basis by the department chairman.

Proctor may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form.

a) **Prospective proctoring**: Presentation of cases with planned outline of treatment for prospective review of case documentation and proposed treatment orders.

b) **Concurrent proctoring**: Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

c) **Retrospective evaluation**: Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient's care.

Each of the above methods may include observation of:

a) History and physical
b) Diagnosis and justification
c) Proposed treatment or procedure and its indications
d) Continuity of care provided to the patients
e) Appropriateness of procedures, tests, and medications prescribed
f) Appropriate use of consultants
g) Appropriateness of length of stay
h) Adequacy of progress notes
i) Adequacy of operative notes

j) Discharge summary
k) Timely completion of medical records
l) Appropriately signed consents
m) Technical skills/knowledge (as appropriate)
n) Use of blood and blood products
o) Punctuality and conduct in OR (as appropriate)
p) Pre and post-operative care
q) Management of complications

Proctoring data from the above methods can be obtained for all admissions of the practitioner or from a random sample. Data may be individual (i.e. case specific) or aggregate "rate" date from multiple cases. Data may be derived from information specially obtained for FPPE or for other purposes. The data obtained by the proctor will be recorded in a FPPE form that has been approved by the Credentials Committee in an effort to structure the proctoring data for consistency and reliability.

Proctoring shall begin with the applicant's first admission or encounter related to a new privilege which, after approval with proctoring has been granted by the MEC and the Board. The duration of proctoring shall be a specific period of time or for a specific number of cases as specified in the Plan and may differ based upon the levels of experience described below.

The practitioner's previous experience may be a factor in determining the approach and extent of proctoring needed to confirm current competence. The practitioner's experience may fall into one of the following classes:

a) A recent training program graduate (within one year)
b) A practitioner with experience of less than five (5) years on another Medical Staff
c) A practitioner with experience of greater than five (5) years on another Medical Staff
d) A gap in continuity of practice

Practitioners in classes a), b), and d) would be candidates for full proctoring programs. Practitioners in class c) may be candidates for limited proctoring upon recommendation of the Department Chair based upon knowledge of the practitioner.

RESPONSIBILITIES:

A. Responsibilities of Proctors

The proctor shall:

- Personally perform the proctoring methods specified in the Proctoring Plan, obtain source data as specified in the Proctoring Plan and complete the Proctoring forms;
- Complete a summary report of the Proctoring forms in a format prescribed by the Department Chair;
- Ensure the confidentiality of the proctoring results, forms and summary report;
- Deliver the completed proctoring forms and summary report to the Medical Affairs office within seven (7) days of the conclusion of the proctoring period.

If at any time during the proctoring period the proctor has concerns about the practitioner's competency related to the specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the Department Chair and provide specific factual information, observation and data to the Chair.

B. Rights and Responsibilities of Practitioner being Proctored

The practitioner being proctored shall do the following as defined in the Proctoring Plan:

- For prospective and concurrent proctoring, notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as is reasonably possible.

- Provide the proctor with list of patients, medical record numbers, any clinical information requested including pertinent physical findings; complete medical chart; pertinent x-ray and lab results; the planned course of treatment or management, operative reports, consultations, and discharge summaries. Documentation must be made available timely so as to conform to the method of proctoring.

- Inform the proctor of any unusual incident(s) associated with his or her patients.

The practitioner under review has the right to:

- Request from the Department Chair or VPMA/CMO if the Department Chair is the proctor, a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. Such requests shall not unreasonably be denied.

- Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of Proctoring forms and the summary report to the Department Chair. The proctoring period will automatically extend for 60 days if the summary report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not submitted to the Department Chair at the end of the automatic extension, the provisional privileges subject to proctoring shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

C. Responsibilities of the Department Chair

Each Department Chair shall:

- Establish for each specialty and subspecialty within their Department appropriate proctoring methods, data sources, duration of proctoring or minimum number of cases to be proctored. When there are inter-departmental privileges, the Credentials Committee shall determine the minimum number of cases, procedures or time period to be reviewed if there is a disagreement between Chairs.

- Assign a proctor to each applicant at the time practitioner is recommended to Credentials Committee for approval.

- Review the medical records of the patient(s) treated by the practitioner being proctored and any other information provided, if, at any time during the proctoring period or at the end of the proctoring period, the proctor notifies the Department Chair that he or she has

concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s). The Department Chair shall interview the practitioner and the Department Chair shall then do one of the following:

a) Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient and/or appoint a new proctor;

b) Refer the case(s) to the Credentials Committee for peer review;

c) Recommend to the Credentials Committee that additional or revised proctoring requirements be required; or

d) Submit a request for a Fair Hearing to the President of the Medical Staff or designee pursuant to the process outlined in the Credentialing Manual.

- At the request of the practitioner or the proctor, recommend extension of the evaluation period to the Credentials Committee if the practitioner, through no fault of his/her own, has not presented the minimum number of cases or procedures within the time required by the Plan.

- At the conclusion of the proctoring period, review the Proctoring forms and summary report of the proctor, submit the summary report to the Medical Affairs office, and make a recommendation to the Credentials Committee for approval of privileges, additional proctoring or denial of privileges.

Responsibilities of the Medical Affairs Office

The Medical Affairs office shall do the following:

- Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:

a) Copy of the privilege form

b) Name, address and telephone numbers of both the practitioner being proctored and the proctor

c) Copy of this PPE policy and the Department's Specialty Proctoring Plan

d) Proctoring form to be completed by the sponsor

e) Provide information to appropriate hospital department about practitioners being proctored, including the name of the proctor and a supply of proctoring forms as needed

f) Periodically submit a report to the Credentials Committee and the MEC of proctorship activity for all practitioners being proctored

g) At the conclusion of the proctoring period, submit the summary report to the Credentials Committee and the MEC.

D. Responsibilities of the Credentials Committee

The Credentials Committee is charged with monitoring compliance with the proctoring policy and procedures. It accomplishes this oversight by receiving regular status reports related to the progress of all

practitioners required to be proctored, as well as, any issues or problems involved in implementing this policy and procedure. The Department Chair shall be responsible for overseeing the proctoring process for all applicants assigned to their department and assuring that the process is completed within a timely fashion. Based on the evaluation of the practitioner's current clinical competence, practice behavior and ability to perform the requested privilege, the Credentials Committee shall determine whether to impose additional proctoring requirements and/or extend the proctoring period, and shall recommend to the MEC whether privileges shall be approved at the conclusion of proctoring. The proctored practitioner shall be entitled to appeal a denial of privileges after proctoring in accordance with the process outlined in the Credentialing Manual.

PRINCIPLE OF PROCTORING:

The proctor's role is typically that of an evaluator, not of a consultant or mentor. A practitioner serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the Medical Center. The proctor shall receive no compensation directly or indirectly from any patient for this service, and he or she shall have not duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner.

The Hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her good faith, acts of omissions in the role of proctor, in accordance with the Saint Francis Healthcare insurance plan.

O. AMENDMENTS, ADDITIONS, DELETIONS

The Rules and Regulations may be changed after a recommended change is approved by the Bylaws Committee, the MEC, and the Board of Directors.